PUBLIC HEALTH NURSING

Official Organ of The National Organization for Public Health Nursing, Inc.

VOLUME 29 AUGUST, 1937 Number 8

A NEW FIELD TO CONQUER

"COVER your left eye like this, Johnny. Please read the letters on the chart. . . . Now cover the right eye."

How many nurses and teachers repeat these familiar words each year in making innumerable vision tests of children! Except for communicable disease control, probably no phase of the school health program is more widely accepted and more methodically carried out. The use of the Snellen chart for testing vision is so simple that any intelligent volunteer can be taught the procedure. Yet it is a safe assumption that a very small percentage of nurses using the test actually knows what it measures, and what are its uses and limitations. There is probably no phase of preventive medicine in which public health nurses are so "unlettered" as that of eye health. Our basic nursing education on this subject is usually very meagre and as a result most of us do not understand even the rudimentary facts about the structure of the eye, how we see, and what happens to various parts of the eye to cause defects of vision. Certainly there is no field in which we have been more complacent with ourselves.

Moreover, except for the Snellen test of central visual acuity in the schools and our efforts to secure prophylaxis in the eyes of newborn babies, our health programs have offered little in the development of a sound, effective, and well coördinated eye health service. It is not enough for the school nurse to know the causes of vision defects and the whys of vision testing, and for the maternity nurse to know the principles of prophylaxis in the eyes of the newborn. Like tuberculosis control, an eye health service, to be effective, must become an integral part of an entire health program. It then becomes necessary for every public health nurse to have a knowledge of eye conditions and their causes, and a sensitivity to symptoms.

A well rounded eye health program includes measures for the prevention of the conditions causing eye difficulties

such as systemic diseases, communicable diseases, and accidents. It means periodic medical examinations of the eyes; early discovery and treatment of eye difficulties; the development of proper habits of eye use and care; the control of environmental factors affecting eyes in the home, school, and industry; educational and occupational provisions for the partially seeing; the development of facilities for diagnosis and treatment of eye conditions; the education, licensing, and supervision of midwives whose care of babies' eyes at birth may mean sight or blindness throughout life; a system for the quick reporting and treatment of eye inflammation in babies; and many other measures. From this it is obvious that the ramifications of an eye health service extend into all other phases of the health program.

The awareness of eye health needs is increasing both on the part of the public in general and professional groups in particular, thanks to the leadership of the National Society for the Prevention of Blindness. This organization maintains on its staff a nursing consultant whose job it is to make the latest information on eye health available to nurses, and to help them strengthen this part of their program. A well rounded program has been outlined for each age-group beginning with the prenatal period, including suggestions for the infant and preschool service, the school health service, and the health supervision of adults—with particular emphasis on sight conservation in industry.

Articles on the subject of eye health in popular and professional magazines are on the increase. Requests for information are growing in number. Public interest is finally being aroused. Schools and industries in particular are broadening their programs and requesting expert guidance in their plans. In response to numerous requests for information on this important subject, PUBLIC HEALTH NURSING is publishing a symposium on eye health—which began in January 1937—dealing with various problems and aspects of eye health.* It is hoped that this series will stimulate further interest on the part of the nurses and a desire for more adequate preparation in this important phase of their work. P.P.

---

*"A School Program for Eye Health—Physical Aspects," Francia Baird Crocker, January-June 1937. Reprints available from the National Society for the Prevention of Blindness, 50 West 50 Street, New York, N. Y. "An Eye Health Program for All the Children," Winifred Hathaway, April 1937. "Saving Eyes in Industry," Vivian V. Jones, June 1937.

VACATION

"SHE WAS beside herself!" What an expressive way to describe that desperate moment we have all known when self-control vanishes and we cannot think or act as ourselves. It really seems as though the *you* you think you have always known has indeed stepped outside and is standing there quite out of touch with the control of the brain.

Probably we are more apt to approach this fortunately very temporary state of affairs when we are tired—and who is not a bit weary after eleven long months of public health nursing? Vacation looks very sweet and we turn to it with a secret longing to find the kind of relaxation and change that will enable us "to get hold of ourselves"—to rest the body and mind so completely that we can stuff that old mind back into its place, tighten up the screws of self-control, tone up the mental and physical muscles, and generally get back inside ourselves!

How to do it? No two inclinations match! For some of us, travel, new faces, new books, study, camping, painting, dancing, or even sleeping!

Most of us, however, have seen a great deal of people in our work. Except for the rural nurses, we have not been long alone. Nearly all of us, too, have sprung from generations of country-born and country-loving people. It is only in the last fifty years that there has been a definite trend of the population to our cities. Our great-grandfathers were close to the earth—here in America, or in the neat fields of England, the dreamy vineyards of Southern Europe, the tip-tilted farms of the North, the wide sun-flooded plains of Russia. We have the love of open spaces in our blood, and it is there, once more close to plain earth, in woods, along shores, on the wind-swept mountain tops that most of us find ourselves.

As we scatter to the four winds for our four weeks' vacation—and the N.O.P.H.N. hopes that every employer has realized the economy of allowing four weeks' vacation on full pay—let us plan our rest so that there comes a day toward the end of vacation when we look back over the past year with a coolly appraising eye and forward to the coming months of work with eagerness, and find both good. D.D.

PACIFIC COAST JOURNAL CELEBRATES JUBILEE YEAR

GAILY dressed in a silver cover, the June *Pacific Coast Journal of Nursing* celebrated the N.O.P.H.N.'s Silver Jubilee year with an issue devoted to public health nursing and the N.O.P.H.N. This journal forms a survey of public health nursing in California, and contains articles on all the various state public health nursing services, including those under the Department of Health, the Bureau of Child Hygiene, and the American Red Cross.

Greetings by Dr. C.-E. A. Winslow and by Dr. W. M. Dickie, Director of the State Department of Public Health; Silver Jubilee messages by Amelia Grant, N.O.P.H.N. President, and Ruth Close, State Lay Jubilee Chairman; discussions of standards and principles of public health nursing, lay participation, and community coöperation; articles on the distribution of public health nursing personnel in California and the expansion of public health programs under the provisions of the Social Security Act: These are some of the features of this special public health number.

The number was planned and worked up through the efforts of M. Louise Floyd, President of the California State Organization for Public Health Nursing, who, together with Agnes Talcott, first President of the Organization and a member of the N.O.P.H.N. Board of Directors, wrote editorials for the issue.

Our congratulations and appreciation to the Journal on this Silver Jubilee commemoration.

Medical Care for the Dependent Aged

By DAVID M. SCHNEIDER, Ph.D.
Assistant Commissioner, New York State Department of Social Welfare

Has science prolonged the average span of life only to condemn a large proportion of the aged to a helpless and hopeless existence? Dr. Schneider discusses this vital question.

MANKIND has traveled far since the days when the aged members of the community were killed off, banished, or eaten by their own children. But many of the essentially tragic aspects of old age still remain. Some of these problems have grown directly out of our modern industrial order; others have been intensified by our new ways of life and labor. Two major spectres still haunt old age—the spectres of insecurity and sickness.

We are all familiar with the vicious cycle wherein poverty breeds disease, which breeds more poverty which breeds more disease, and so on. This cycle affects the poor at all age-levels, but it leaves its most disastrous mark on the old-age group.

In many respects, the problems of dependency and disease in old age are inherent in the very nature of progress. The great advances in medical science, sanitation, and hygiene during the past half century have made it possible for ever-increasing numbers of people to reach old age. The expectation of life at birth is three times greater than it was among the ancients, contrary to the popular saying that "people lived longer in the good old days." In the past six decades, the average life span has increased from forty to nearly sixty years. At the same time the drastic curtailment of immigration and the rapidly falling birth rate have also served to increase the proportion of elders in the total population.

According to recent estimates, there are now in this country more than 7,500,000 persons 65 years of age and over. While the proportion of aged people was only 3 percent of the population in 1870, it has grown to 5.4 percent in 1930.[1] Professor P. K. Whelpton calculates that by 1975 the number of persons 65 years of age and over will exceed 20,000,000, comprising nearly 13 percent of the population.[2] This impressive proportion of the aged in the population is a phenomenon peculiar to our times. As Dr. Louis I. Dublin says, "It is only in recent decades and in highly advanced countries that we are confronted with large numbers of people who live to old age."[3]

ECONOMIC HAZARDS OF OLD AGE

But while certain factors have made it possible for more people to grow old, other developments have been increasing the economic hazards of old age. Industrial progress and the rise of urbanization have taken great numbers off the farms, where old people might still function in the economic scheme. In the highly industrialized society of today, with its fierce competition in the labor market, the man of limited efficiency finds it increasingly difficult to obtain a job. Speed-up and the dis-

---

Presented before the Joint Meeting of the American Sociological Society and the American Association for Labor Legislation, December 28, 1936, Chicago, Ill.

placement of man by the machine have hit the older workers the hardest. For the unemployed man over 45 years of age, the chances of being reëmployed are lessened in direct ratio to increasing age.

Shorter periods of work, longer periods of unemployment, occasional illnesses with heavy drains on savings—these and other factors stand in the way of building up reserves out of one's earnings, and intensify the problem of old-age insecurity. Naturally, the great economic crisis has rendered the problem even more acute, though it is important to remember that the problem transcends the cyclic depression. It is inseparably bound up with the prevailing economic system, and will be present in normal and abnormal times.

Modern civilization, then, has given the average man a better chance for a long life, but it has given him no corresponding security to permit him to enjoy his added years. Indeed, it has taken from him a measure of security that was his under feudalism and during the long period of a dominantly agricultural economy that followed. In those days elders occupied a patriarchal place which brought them respect and veneration, as well as the relative economic security stemming from a large, closely integrated family group. The industrial revolution has brought in its train a weakening of family ties. Today the family is small and the children are scattered. Rentals in urban communities put apartment space at a premium and increase the burden of providing for aged relatives at home.

While there are no accurate statistics of the extent of old-age dependency, a survey made for the Children's Bureau in 1930 estimated that one-third of those 65 years of age and over were indigent.[4] The proportion of dependents has undoubtedly grown since the onset of the depression.

It cannot be denied that the question of old-age security has received a generous amount of public attention in recent years. It even bade fair for a time to become a leading issue in our late presidential campaign, when a modern Moses from out of the West tried to mobilize an army of the aged to lead them as the Chosen People to the Promised Land. Though some of the schemes lately set forth for alleviating or eliminating the miseries of old age may be characterized as crackpot panaceas, they have served a useful purpose in attracting attention to a serious problem.

PROGRESS IN OLD-AGE SECURITY

The last few years have witnessed a rapid advance of old-age assistance laws throughout the country. By the end of 1935 such laws were on the statute books of 39 states and the District of Columbia. In August, 1935, the Federal Social Security Act was passed, incorporating an old-age assistance program among its provisions. According to the U. S. Bureau of Labor Statistics, there were more than 236,000 persons receiving old-age assistance in 1934, twice as many as in the previous year. It is disturbing to note, however, that while the number of beneficiaries rose 104 percent in 1934, expenditures increased only 23 percent. There was a marked decrease in the average monthly allowance, the rate falling from $19.34 to $14.69.[5]

It is easy to see that an average monthly allowance of $14.69 hardly constitutes a security level, even taking into consideration the diminished material needs of the aged. We are too often inclined to think that we have done our duty to the aged when we have provided them with just enough to keep the spark of life aglow. This concept is incompatible with present-day ideals in social welfare. Old-age security that is limited to the provision of bare material necessities is not enough. Our

dependent aged deserve more and should get more. For what would it profit a man if science made it possible for him to live to be as old as Methuselah, if he could look forward only to a bleak, bitter old age filled with misery and ill health? Why prolong life if we cannot make the added years worth living? To borrow a phrase recently applied to our neglected children, "Why keep them alive?"

SICKNESS CONFUSED WITH SENILITY

In our efforts to make dependent old age more livable, we are learning to recognize sickness as a major problem in any program of old-age assistance. From all indications, a large proportion of our aged indigents are experiencing unnecessary sickness and suffering due to our failure to consider their medical needs. Our neglect in this respect is not occasioned so much by cold indifference as by a common tendency to mistakenly identify sickness with senility, as though the two were inseparable. When we witness sickness and suffering in our old people, we tend to adopt an attitude of impotence, ascribing their misery to the natural processes of senescent deterioration. We hastily diagnose the illness as simply "old age" and let it go at that. While it is true that the susceptibility to sickness increases during the process of aging, it is also true that good health and old age are not incompatible. The maintenance of a maximum degree of health in recipients of old-age assistance is a worthy goal for public welfare authorities. We can try to save our old people from the terrible seventh age described by Shakespeare: "sans teeth, sans eyes, sans taste, sans everything."

Most illness of old age involves chronic diseases that have been developing for many years and have gone beyond the stage where preventive measures are possible. However, such chronic illness and the pain it engenders can be checked and mitigated, if properly diagnosed and treated.

There are no available statistics on the general prevalence of illness among recipients of old-age assistance in the United States, or on the extent to which their medical needs are being met. However, the experience and findings of New York State in administering its old age security law may serve as an indication of the magnitude of this problem. New York ranks among the three leading states in its provision for old-age allowances.[5] The average grant paid out in 1935 under its old age security law amounted to $21.36, as compared with an average of $14.69 throughout the nation in the previous year. It should be pointed out, in this connection, that the New York State old-age assistance program is a flexible one, and allows for additional income on the part of the recipient. Thus, its standards are actually somewhat higher than the bare figures would indicate.

ALLOWANCE INSUFFICIENT FOR NEEDS

Yet it is obvious that this comparatively liberal allowance was insufficient to provide for medical needs, after such essentials as food, rent, and clothing—not to mention fuel, light, and other items—were paid for. In fact, it was found that an average of only 52 cents monthly was being spent for medical care. Even this negligible sum was in many instances spent unwisely in the purchase of quack remedies and over-advertised patent medicines. The State law specifically orders that each public welfare district shall provide appropriate medical care to recipients of old-age relief. Nonetheless, available data show that the medical needs of the latter are not being adequately met. This is true even of New York City, where the average monthly old-age allowance in 1935 was $25.90.

A survey of the medical needs of recipients of old-age assistance was recently completed in New York City. A sample of 1000 out of a total number of

23,000 recipients were included.[4] All those covered in the survey were 70 years of age and over, since the study was made prior to the new statute reducing the minimum age limit to 65. Some degree of disability was found in three-fourths of the total number of recipients examined. More than two-thirds of the cases suffering disability were up and able to get about; the remainder were either home-bound or bedridden. Significantly enough, nearly one-fourth of the persons studied had no obvious disability; that is, no condition was found that interfered with their ordinary activities. It is noteworthy that about 3 percent were found entirely free from disease, confirming the view that old age, when unaccompanied by actual pathological conditions, is not disabling in itself. There are also many mild diseases which do not incapacitate the aged.

FEW RECEIVE MEDICAL CARE

The committee conducting the New York City survey found that "comparatively few" of the aged recipients of relief who required medical care were actually receiving it. Medical care includes diagnosis and treatment in a hospital or dispensary, or care by a visiting physician, nurse, or trained attendant, or by an untrained attendant under medical supervision. More than 40 percent of the total number of persons examined were in need of medical care and were not receiving it. Even among those receiving some medical attention, a large proportion were obtaining an inadequate amount. It is obvious, then, that the problem of providing adequate old-age assistance is in large measure a problem of providing medical care.

Besides the purely medical problem involved in the relationship between sickness and old-age dependency, a number of social factors, such as environmental conditions, personal and physical, play a profound and often a determining part in the situation. In general, the indigent aged outside of institutions may be divided into two groups: those who live in families, with relatives, friends, or strangers; and those who live alone, usually in lodging houses. Social workers are aware of the great strain created by prolonged illness on the varied relationships within a family group. The attitude of members of the family toward the patient may tend to improve or aggravate his condition. Conversely, the presence of a home-bound or bedridden old person requiring constant attention may serve to create unhealthy tensions and antagonisms within the group. The particular type of illness from which the patient suffers may have an important influence on his personality and on his attitude toward life.

ENTIRE FAMILY AFFECTED

Medical research has recently found remarkable affirmations of the relationship, known to the ancients, between certain organic diseases and emotional and mental attitudes of the individual. The mere presence of an aged invalid at home may have a depressing effect on the rest of the family; in addition, the patient may be alternately plaintive and dictatorial, and highly self-centered, demanding infinite care and patience on the part of the family. Not infrequently he acts as a deteriorating or disintegrating force on family life. Here we find a situation where proper medical care, included as part of a well rounded public assistance program, may have a beneficial effect not only on the patient but on the whole family group. The application of social case work to such situations, supplementing medical care, can be very useful in effecting satisfactory adjustments in the relations between the patient and the family group.

Aged dependents living alone, in lodging houses and elsewhere, present special problems of medical care and super-

vision since their infirmities are likely to go unnoticed. For that matter, although an aged dependent living within a family group is assured of some measure of care and protection, family life by no means guarantees adequate medical attention. The New York City survey revealed many instances where recipients of old-age assistance who were living with families were in dire need of medical attention which they were not receiving.

The New York State Commission on Old Age Security, in its report of 1929, concluded that any measures proposed for the improved care of the aged poor that do not go beyond the mere provision of financial relief will not meet all the needs of the class of people who are at present dependent.[6] If we are to formulate a well rounded program of old-age security, we must come to grips firmly and finally with the long-neglected problem of medical care. What would such a program include in the way of meeting the medical needs of aged indigents? It would include, as the committee making the New York City survey suggested, a thorough medical examination of all applicants for old-age assistance. This would serve as a guide for proper treatment, carefully integrated into the whole program for assistance on the basis of individual needs.

WHAT CAN BE DONE?

Such a comprehensive program would probably require close coöperation between public welfare administrators and public health authorities for mutual attack on the related problems of dependency and disease. There should also be a pooling of resources between public and private agencies for the more efficient distribution of services. Regular medical attendance and periodic diagnostic studies would have to be provided, utilizing the facilities of hospitals and dispensaries. Since old people, for obvious reasons, often find attendance at general clinics difficult if not impossible, a special clinical service might be arranged for them. Provision should be made for adequate home treatment and care by visiting physicians and nurses. In this respect, a partial solution might be made of the unhappy paradox posed by the Committee on the Costs of Medical Care, which found that many physicians are sitting idly in their offices waiting for patients, while there are thousands of individuals who want and need medical care, but who cannot afford to pay for it.[7] Thoughtful provision of simple appliances, such as glasses, aids to hearing, trusses, braces, and wheel-chairs, frequently add greatly to the contentment and comfort of the aged. An expanded housekeeping service for aged indigents would be part of this comprehensive program.

Regular visits by social case workers or public health nurses or both would be made to recipients of old-age assistance, to keep apprised of changing health and living conditions and to secure satisfactory individual and family adjustments. This aspect of the total problem has been very inadequately met thus far. The social case worker or public health nurse could concern herself with such problems as the suitability of the physical environment (factors such as sanitation, heat, light, and fresh air); the composition of the family, judged from the viewpoint of the ability of the family group to provide for the needs of the sick dependent; and the all-important factor of the reciprocal emotional relationships between family and patient. She could help to overcome the fatalistic tendency to confuse sickness with senility, resulting in a do-nothing policy. With the passage of time, perhaps, the services we have mentioned might be extended to cover not only dependents, but all old people in the lower-income brackets.

After a life spent in work and worry, participating in the building up of social

wealth and well-being, the old person is entitled to spend his last few years on earth with a measure of decency and comfort compatible with the standards of human dignity in modern civilization. Shall we say that science has prolonged life only to condemn a large proportion of aged to a dreary, monotonous, hopeless, and helpless existence, full of suffering and sickness? Should biological science declare a moratorium on its efforts to extend the term of life? I think not. Rather must social welfare keep step with science, and provide means for enriching the content of life in old age. Let us help people to grow old gracefully. Let us make it possible, so far as it lies within our capabilities, for people to look forward to an old age pictured so warmly by Robert Browning's philosophic Rabbi ben Ezra:

Grow old along with me!
The best is yet to be,
The last of life, for which the first was made:
Grow old . . . . nor be afraid.

REFERENCES

[1] U. S. Department of Commerce, Bureau of the Census. Abstract of the Fifteenth Census of the United States, 1930. U. S. Government Printing Office, Washington, D. C., 1933, p. 182.

[2] Whelpton, P. K. "Increase and Distribution of Elders in Our Population." *Journal of the American Statistical Association,* Vol. 27, March 1932, p. 149.

[3] Dublin, Louis I. Health and Wealth. Harper and Brothers, New York, N. Y., 1928, p. 149.

[4] A Study of the Medical Needs of Recipients of Old Age Assistance in New York City in 1934. State Department of Social Welfare, Albany, N. Y., 1937.

[5] U. S. Bureau of Labor Statistics. Handbook of Labor Statistics. Bulletin No. 616, U. S. Government Printing Office, Washington, D. C., 1936 edition, pp. 601-602.

[6] New York State Commission on Old Age Security. Report transmitted to Legislature February 17, 1930. J. B. Lyons Company, Albany, N. Y., 1930.

[7] Committee on the Costs of Medical Care. Medical Care for the American People. The University of Chicago Press, Chicago, Ill., 1932.

WHEN IT'S HOT

When the thermometer goes up do you just suffer along as best you can or have you a favorite dozen or so of "Hot Weather Hints" to fall back on, which make for increased comfort?

Here are 12 issued by the *Connecticut State Department of Health:*

1. Time goes on in spite of snows of winter, floods in the spring, and sizzling heat of summer—so why worry about it!

2. Go about your daily tasks and leave the thermometer alone—it has its own business to attend to.

3. Get in a breeze if possible. Fanning may help, though it may make you hotter.

4. Avoid excessive dratts when you are overheated.

5. Vigorous sports in the hottest part of the day may lead to sunstroke or heat exhaustion. Better shift these to cooler parts of the day.

6. Plenty of cold water is a health measure, but ice water should not be taken too freely or too fast.

7. Dress in white or light-colored clothes, for dark colors absorb the heat.

8. Excessive energy used in arguments is heating. So, as in other things, be moderate in your conversation, especially the controversial kind.

9. Use the shady side of the road when you have some distance to travel to avoid the heat and glare of the sun.

10. Stick to a well balanced diet with emphasis on salads, vegetables, fruits, and milk, avoiding excessive protein foods. Hot foods should not be eliminated entirely during hot weather.

11. Rest awhile during the hottest part of the day. Adopting the "siesta" plan of the South where all activity stops during the noon hour is recommended.

12. Take your vacation activities in moderation, curbing as much as possible your enthusiasm for marathons.

—*Weekly Health Bulletin,* June 27, 1936.

Making New Friends for the V.N.A.

By ELISE S. HAAS
Chairman, Coöperation and Publicity Committee
The Visiting Nurse Association of San Francisco, California

An effective program of public information in regard to the service offered by one visiting nurse association is described by the chairman of the agency's publicity committee

"GOOD afternoon. This is your visiting nurse speaking." So begins a weekly broadcast of the San Francisco Visiting Nurse Association, a broadcast which has been carried on as one of the organization's efforts to interpret its service to the public during the past two years.

In January 1935, the Board of Directors of the San Francisco Visiting Nurse Association, feeling that the service of their organization was not sufficiently well known to the community and therefore not fully utilized, determined to make the chief business of that year an active and aggressive publicity campaign. Accordingly, the Publicity and Coöperation Committees were fused under one head, and plans for various types of publicity were outlined. These plans included a concerted drive to secure greater coöperation from the medical profession and the hospitals, and advocated the use of the radio—a new tool to us—in addition to such avenues of interpretation as the newspapers, clubs, and parent-teacher associations, to make known to the general public the many types of nursing service available to them through the Visiting Nurse Association.

The personnel of the committee was chosen from the Board of Directors and is composed of members with varied interests and diversified contacts. One member has had experience in the advertising business and has done newspaper writing, which is invaluable to the committee in helping with techniques and methods of publicity. The other members have participated in making contacts of all sorts, and in activities such as distributing leaflets, and keeping in touch with the hospitals and organizations through which our publicity has been carried on.

The opening gun of the campaign was trained upon the hospitals. Attractive blue leaflets describing our maternity service, with the caption "The Bathing and Care of a New Baby at Home," were placed in the leading hospitals, which in turn distributed them to their maternity patients when they were ready to return home. As a result, we had so many calls for this educational follow-up service that it was necessary to print 500 more leaflets. In addition to the hospitals, three large department stores consented to inclose one of these leaflets in every package bought in their infant departments.

Through the courtesy of the director of art in the public schools, a poster contest was arranged with several objectives in view. The first purpose was to further acquaint families of San Francisco with the services of the Visiting Nurse Association. This development of interest, we thought, could be more easily accomplished through creating a wider community interest among the school children.

The second purpose was to obtain

new and striking posters to place in doctors' coatrooms in various hospitals, and if possible to secure an effective poster for general publicity purposes. About forty-five posters from five high-school art classes were submitted. They were judged by a distinguished committee of artists and laymen and exhibited for ten days at the San Francisco Museum of Art. Award boxes of paints were given to the three prize winners, and fifteen of the best posters were selected for distribution among the hospitals. Our slogan, "Remember the Visiting Nurse Association," made quite an impression upon many of the doctors, who thought the whole plan an excellent one.

CHILDREN VISIT V.N.A.

During the contest many school children visited headquarters to familiarize themselves with our work, and impressed by their interest, we plan to hold an essay contest at some future time—for which we have already secured the coöperation of the newspapers. The newspapers, including neighborhood publications and Japanese newspapers, have been most helpful. They have published several editorials on the Visiting Nurse Association, as well as many articles on the maternity service, work with cardiac patients, our tenth anniversary tea, the Christmas party for our old people, and frequent items about our board meetings.

Twelve talks were given during the year before parent-teacher associations by our director, and the Speaker's Bureau of the Community Chest called on her several times during their campaign for talks before various clubs and organizations. A large department store in one district offered to pay the association fifteen dollars a month for health talks to be given twice a month in the store. Invariably the lecture resulted in at least one call from someone in the neighborhood.

For our radio broadcasts, a local station, KJBS, very generously offered to contribute five minutes a week for a series of talks for the association. After considerable experimenting and several meetings with the Medical Advisory Committee, the type of broadcast chosen to be given over the air was the interview, consisting of questions and answers between the director of the Visiting Nurse Association and the announcer on various health problems and the ways in which the nursing service helps to solve them. It so happened that after an audition of several members of the staff, it was found that the director's voice was the one best suited for radio broadcasting.

The announcer usually began by making a brief statement on the services of the Visiting Nurse Association; and at the conclusion of the interview, he gave our telephone number, ending with: "Remember the visiting nurse is as near as your telephone."

SUBJECTS OF BROADCASTS

Some of the subjects discussed were: Prevention of Colds, Child Management, Measles, Immunization, The Better Half of Life. The broadcasts are prepared by the director and the station announcer—who is paid a small sum for his assistance. Although the results from this form of publicity are somewhat intangible, the director has reported that the nurses from time to time have had favorable and interested comments and that a certain number of calls have been definitely traced to this source.

To supplement our regular advertisement in the County Medical Society Journal, certain members of our Board of Directors attempted to "sell" the Visiting Nurse Association to as many physicians as they could personally contact. Some members of our Board made personal calls to the offices of the physicians. They were well received

and found most of the doctors were ready to coöperate—but rather forgetful; so, in addition to distributing descriptive pamphlets, we plan to supply physicians' offices with amusingly illustrated blotters in the hope that a reminder always at hand will induce them to remember the Visiting Nurse Association more often. The results of this intensive and personal campaign are already apparent, for in 1935 we received 567 calls from physicians as compared to 437 in 1934—an increase of 130 or about 30 percent over that of 1934.

The budget allotment for publicity in 1935 was $350, of which we used $341. This was an increase from $150 in 1933 and 1934, and represented a partial return to the predepression allotment of $450 in 1932. While it is difficult to determine the actual results from the various forms of publicity mentioned in this article, it is gratifying to know that in addition to a general increase in the use of our service, the amount of money collected from pay patients advanced from $4205 in 1934 to $5144 in 1935, an increase of $939 or 22.33 percent. In 1935 the pay service showed the greatest increase; in 1936 our part-pay service has also increased materially. And perhaps the greatest satisfaction of all is to see the eagerness with which the people of our community welcome our services when they know what the Visiting Nurse Association can do for them.

CAN CAREFULLY

During the canning season, housewives in urban and rural areas are busy with the preserving of fruits and vegetables, in preparation for the winter months. It is a matter of wonder how the canning process, properly carried out, preserves perishable foods for months and even years.

The main principle in canning is the application of heat through prolonged boiling. Spoilage of fresh fruits, meat, and vegetables is due to processes of fermentation and putrefaction; these in turn are dependent upon bacteria. High temperature and the canning process destroy bacteria, prevent spoilage, and make possible the preservation of food over long periods of time.

Fatalities occur from time to time through faulty technique in the home-canning process. The most serious condition is that known as botulism, a type of food poisoning due to the toxic products of botulinus germs. These germs, distributed in the soil and at times in the intestinal canal of animals, have a spore form which is peculiarly resistant to heat. Home-canned string beans, corn, and pork are sometimes subject to contamination with these bacteria and the toxin or poison which they produce. Symptoms are those of disturbed vision, difficulty in swallowing, and progressive muscular weakness. Fortunately botulism occurs but rarely. Laboratory study, and this alone, throws light upon the exact nature of food contamination.

Some of the means of preventing the type of food poisoning which causes botulism are as follows: (1) Only fresh foods which have been washed thoroughly should be used for canning. (2) Meats and vegetables require prolonged cooking, preferably at 120 degrees Centigrade in a pressure cooker, before canning. (3) Canned meats should be cooked thoroughly just before serving. (4) Cans or jars which have gas formation (bulged lid), rancid odor, or spoiled appearance should be discarded.

—*Weekly Health Message,* The United States Public Health Service, in coöperation with Iowa State Department of Health, September 21, 1936.

Courtesy Grosset and Dunlap

Puppets take their place with other avenues for interpretation of health services to the public

Marionettes Become Health Conscious

By EDITH S. COUNTRYMAN, R.N.
Director, Public Health Nursing, Iowa State Department of Health, Des Moines, Iowa.

PUPPETRY first interested me when the nursing staff of the Iowa State Department of Health began making plans last year for the preparation of exhibits and demonstrations at the Iowa State Fair. Every staff member seemed to be running around in circles trying to get at least one new idea for the booth. The chief aims were to produce something about the county health units that would interest the public, and to demonstrate the value of maternal and child health class work. Both subjects had soared into prominence through the reorganization of departmental plans for better health for mothers and babies as well as better health for the general public.

The puppet show was the brain child of a new staff nurse. All the staff members took an active part in contributing suggestions for the skit, which had for its title:

"INFANTICIPATING AT THE KELLY'S"

The nurses did not think they had the dramatic ability to carry out this first performance before a state-fair audience. Someone conceived the idea that the WPA had people waiting for opportunities to put their talents into action. The state director of women's work was consulted and gave the necessary assistance needed for perfecting the project. The WPA had women experienced in making the simple kinds of puppets, which were suitable for the type of playlet to be produced. The puppets were made; the skit was written; scenery was produced; and the curtain was ready to go up on the department's first attempt in the field of drama. The queer cloth

puppets, as I think of them now, were but excuses of things compared to the kinds I have met since then.

While attending the university in 1936 I took some courses in puppetry both as an avocation and in the hope of using it later as a vehicle for the introduction of certain phases of the health program to the public.

Those who have worked with puppets realize that there is a lot of life in these attractive "funny faces" when properly manipulated. At first I concentrated on the making of hand puppets, a project which was a regular part of class instruction. This type of puppet fits over the hand in glove fashion and is operated by the fingers which fit into the head and the arms. String puppets are much more difficult for the average person to use, but if there is someone in the community who can swing them into motion they are by far the more interesting type to work into the play.

I shall not attempt to describe the details of puppet making for it would be too difficult a task to create them without an experienced person for a guide. Those who are interested in any of the different types of puppets as a form of presentation of health work, but who are not adept in making them, will undoubtedly find many avenues where they may be secured.* There should be a set for every individual play as the characters must have special representative features.

The following playlet is quite in keeping with present-day public health nursing programs and it is the one that was used at the 1936 Iowa State Fair. It held the audience every minute. Fathers, mothers, grandfathers, and grandmothers as well as teachers and clergymen all became so interested that they remained until the drop of the final curtain. Children showed special interest especially in the movements of the figures held by the strings and many returned several times to see the performance repeated.

The wording of this playlet was carefully planned and written, then revised and revamped until it carried the message in a dignified but rather humorous manner. Our experiment in Iowa showed that puppets are of real value in putting over many ideas which seem difficult to present before a roving audience such as is found at state and county fairs.

*Ackley, Edith Flack. How to Make Marionettes. Grosset & Dunlap, Inc., New York, N. Y., 1936.

INFANTICIPATING AT THE KELLY'S

CHARACTERS

Mrs. Kelly	Mother-in-law of Kate
Kate Kelly	Young expectant mother
Mrs. Murphy	Kate's own mother
Pat O'Brien, M.D.	General medical practitioner
Public Health Nurse	County nurse

MRS. KELLY	Big, energetic type. Very red of face and hair. Voice gruff with decided Irish brogue. Dries perspiring brow frequently with a very gaudy handkerchief. Addicted to loud colors in dress.
KATE KELLY	Pretty, average appearing young woman.
MRS. MURPHY	Thin, plaintive type. Dressed very conservatively for street.

DR. PAT O'BRIEN	Very crisp in speech. Dressed in a white gown or white jacket.
PUBLIC HEALTH NURSE	Young. Wears public health uniform of the color and type used by the local nursing organization in the community.

SCENE I

Scene opens with the three women in the waiting room of Dr. O'Brien. Mrs. Murphy and Kate on one side of the room. Mrs. Kelly on the other. Center table is covered with papers to resemble magazines. Something on the wall to resemble medical certificate with class pictures. Door to inner office visible. Sign on door to read: DOCTOR IN. BE SEATED.

MRS. KELLY: (*Puffs a bit. Wipes brow with loud handkerchief. Sits down and says*) Shure an' I think it's a waste of toime and money to be runnin' afther the doctor like this.

KATE KELLY: (*Sitting down in chair*) But, Mother Kelly, Timothy insisted on my coming.

MRS. KELLY: (*Acts out following statement*) An' I didn't go chasin' afther the doctor every toime I had an ache or a pain when I expected aiven Timothy. It's pure noinsince, it is. (*Sits down decidedly*)

KATE KELLY: (*Gets up. Turns to Mrs. Kelly*) Doctor Pat wants me to see clearly and understand what lies ahead so that I won't need to get unusual aches and pains. You said yourself it is better to use foresight than hindsight.

MRS. MURPHY: (*Points to head and body*) That is right, Katy. It is better to be safe than sorry later on that you didn't give your baby the things he is entitled to—a normal mind and body.

MRS. KELLY: (*Sniffs loudly*) Can you be afther tellin' me, Mrs. Murphy, why *you* should be advisin' your daughter to waste my son's money runnin' to a doctor every month. Shure an' you had half as many babies as I did an' you were lucky if the doctor got there at all before they were born. (*Waves both arms as if expressing "Tush-Tush"*)

MRS. MURPHY: (*Walks. Turns to Mrs. Kelly*) Yes, I know, Mrs. Kelly. But I have four graves and one sickly boy to show for my carelessness and neglect. (*Wipes eyes with handkerchief. Goes to Katy and puts hand on her shoulder*) Katy here is the only one of the six that was born healthy as babies should be born and that was just luck.

MRS. KELLY: (*Raises both arms and lets them drop to lap. Shakes head*) You can't be afther changin' the will of God, Mrs. Murphy, an' runnin' afther the doctor could not have changed it at all, at all.

MRS. MURPHY: (*Mrs. Kelly walks to table*) I'm not so sure about that. Perhaps if I had gone to see the doctor before my babies came as Katy here is doing, I'd have my babies grown into men and women to comfort me in my old age. (*Walks to Mrs. Kelly's chair*) I'm going to see that Katy don't make the same mistake. I'll see that she visits Doctor Pat as often as he advises so she and baby will be strong and healthy.

DOCTOR: (*Enters and speaks as he moves across the room to shake hands with*

Mrs. Murphy) Good morning, Mrs. Murphy. You're perfectly correct in what you just said. We *are* going to see that Katy is well taken care of and that young Tim gets the start in life he is entitled to. (*Doctor pats Katy on the shoulder and then crosses room to greet Mrs. Kelly*) I'm surprised at you, Mrs. Kelly. The will av God (*Imitates Mrs. Kelly's brogue*) as you call it, is blamed for far too many deaths that are unnecessary and in most cases due to the carelessness and neglect of expectant mothers and fathers. (*Paces back and forth with arms behind back*) I think we'll have to send you along with Katy to the Motherhood Class. Perhaps we can teach you that some of your old-fashioned notions can be improved upon, Mother Kelly.

MRS. KELLY: (*Waves arms*) Classes for mother, is it? Well, niver let it be said that a Kelly by marriage and O'Shaunessy by birth iver refused to learn anything. And what will I be afther learnin'?

DOCTOR: (*Imitating brogue. Walks toward Mrs. Kelly*) Shure and you'll be afther learnin' how to take care of the baby before and afther he arrives. (*Doctor returns to normal speech*) I'm going to see that Katy also gets the eight prenatal letters from the state department of health to help keep her on the path of safety. (*Disappears and curtain is drawn to shut out Katy and the Doctor*)

SCENE II

The three women characters and as many characters for audience as possible are seated on chairs in Kelly living room. Nurse standing at the table arranging papers. Mrs. Kelly wipes her brow frequently. Mrs. Murphy fans self with newspaper.

MRS. KELLY: Shure, an' we all got along without public health nurses runnin' to our house to have classes. But I say again, I'm not too old or too stubborn to learn somethin' new.

KATY: (*Raises hand to mouth*) Shhhh! Mother Kelly. The nurse is ready to start the class.

MRS. KELLY: (*Waves hand at Katy*) Shure an' I'm ready to listen.

NURSE: (*Walks across front of room*) Ladies, we are just going to plan our classes today. The lessons will include a discussion of how to keep well during pregnancy; what prenatal care is and why it is necessary; how to prepare the baby's layette and the things that will be needed for its care; and what preparations should be made for confinement at home. A doctor will talk to us about the medical care of mothers and a dentist will tell us how to protect the teeth of the mother and baby.

MRS. KELLY: (*Waves arms*) Shure an' maybe it isn't such a lot of noinsinse at that.

KATY: (*Waves arms toward Mrs. Kelly*) Why just last week Tim told me that he has suffered from indigestion all his life and he hasn't a good tooth in his head.

MRS. KELLY: (*Shrugs shoulders*) It's perfectly natural, it is. He takes that afther the father's side of the family. They all had poor teeth.

NURSE: (*Walks closer to class*) No, Mrs. Kelly, that isn't natural at all. If you had visited the dentist and learned about dental hygiene before your son was born, as these mothers plan to do, he would have had better teeth. (*Walks toward door*)

MRS. KELLY: (*Waves arms toward nurse*) It's still a little snippet I'm afther thinkin' she is but she certainly told me a thing or two.

SCENE III

Kelly living room. Mrs. Kelly holding a small baby.

MRS. KELLY: (*Sings snatch of Irish lullaby. Katy enters room, walks over to look at baby*) Shure an' it's a fine bye, that he is. Just the spittin' image of his grandfather, Timothy Patrick Kelly. (*Pats baby*) But it's a wonder to me he looks like anything at all with all the fuss and fixings before he got here. Diets and exercise it is and makin' his clothes with no buttons on and just as plain as they can be. It's a lazy woman that sews on strings instead of buttons.

KATY: (*Katy straightens up and looks at Mrs. Kelly*) But Mother Kelly, his little slips and nighties are so much easier for me to iron and for him to lie on. I learned that trick at the motherhood classes.

MRS. MURPHY: (*Enters, looking at baby*) What a sweet little one. I think at least the first baby's things might have a few fancy trimmings. They seem to fit all right and be comfortable but they are *so* plain. (*Looks toward Katy*) Goodness knows, you had enough time to fix things fancy with Tim helping you with your housework. (*Waves arms*) I declare to goodness, I never saw a man help so much in my life. (*Walks over to chair and sits down*).

KATY: (*Clasps hands*) Tim is grand isn't he? (*Waves arms*) But I can thank Doctor Pat and the public health nurse for their advice about sharing the responsibility of parenthood even before the baby arrives. The plainer the baby's clothes are the less time it will take to launder them and the more time I'll have to spend with my Big Tim and our Tiny Tim.

MRS. MURPHY: (*Walks over to Mrs. Kelly*) Perhaps if we'd known all those things, Mrs. Kelly, we might have done a better job of raising our families.

MRS. KELLY: (*Looks at Mrs. Murphy*) Well, I must admit it isn't such a lot of noinsince as I thoight it was. Little Tim is the best baby I ever saw. (*Pats baby*) Why! he don't even cry because there is not toime marked on the schedule for it.

KATY: (*Walks around table as though straightening things up a bit*) Now, Mother Kelly, you know he does cry sometimes. But he is a good baby and I'm going to follow the rules Doctor Pat and the public health nurse laid down until they find better ones to follow.

MRS. KELLY: (*Throws arms in air*) Glory be! If I don't think you are right at that. I'm just an old-fashioned woman but I have sense enough to know that young Tim is the healthiest young'un I ever saw. If it is because you ran afther Doctor Pat the way you did, then I hope you do no different with the other twelve to make up a baker's dozen.

CURTAIN

Board and Staff Relationships

By EVELYN K. DAVIS
Assistant Director, National Organization for Public Health Nursing

What should be the attitude of the board toward the professional staff? Of the staff toward the board? Miss Davis' rich and varied experience in board and staff relationships is evident in this penetrating discussion

IN ORDER to analyze more clearly the question of board and staff relationships it is important to consider the subject historically. Certain traditions from the past inevitably affect present-day progress, and the past has undoubtedly colored some of the relationships we find existing in social work agencies at the present time.

Many years ago when various types of philanthropic work were being developed, board members were the "lady bountiful" type, or crusaders, and they adopted a most possessive attitude towards the organization and the staff. This organization was "Mrs. Jones' pet charity," that agency was "Mr. Smith's." The membership of the board was frequently drawn from one rather limited social group. The board decided everything—policies, programs, even the details of the work itself. The staff was thought of as clerks or office help and did the bidding of the board.

The next step in the development of social work was the recognition for the need of trained workers. During this era, great emphasis was laid on the maintenance of professional standards and the feeling that the professional worker should run everything. The board now became a mere rubber stamp in some agencies. They were needed, of course, to raise money, but too often the members were selected for window-dressing only. They themselves either had a great deal of money or were able to persuade the rich members of the community to contribute.

Both in theory and in practice these two stages were unsound, and we have been emerging for several years into the third stage—one that I like to call a partnership relationship. This relationship is a partnership of equals—equal in the fact that both the board and the professional staff are interested in developing the very best type of organization to meet the needs of the community. In this relationship neither group is dominant, but both are working together and thinking as a group of the development of the program which the agency is organized to carry out. In this relationship we should not have the board telling the staff what to do or sitting back saying they have such a good staff there is little for them to do. It is just as unsound for the staff to do too much for the board as it is for them to do too much for their clients or patients.

However, history has played its part in the relationship which we find today and we see attitudes still existing which are colored by these previous stages I have outlined.

Presented at the meeting of the National Committee on Volunteers in Social Work, National Conference of Social Work, Indianapolis, Indiana, May 27, 1937.

Let us do a little self-analysis of present-day attitudes. It is very healthy to sit down occasionally and analyze our own actions and thoughts, and at the risk of appearing rather negative I am going to point out some attitudes which I have found existing on the part of various board members and professional workers throughout the country. Not that the illustrations which I am going to use are generally prevalent, but they still do exist in some situations. If we are going to develop this effective partnership relationship, it is most important to avoid some of the feelings toward each other that I have found both board members and professional workers entertaining.

PROFESSIONAL WORKERS' ATTITUDES

We find professional workers who feel that the board is a necessary evil; on the other hand we find a good-natured tolerance towards the board.

Occasionally we find professional workers feeling that board members cannot possibly understand their problems or their clients' problems, as the average board member has never had to work for pay or felt insecure financially.

We find professional workers feeling inferior socially to the board members; we find them feeling superior intellectually.

We find them talking in professional terms which board members cannot understand. There is a tendency sometimes to go too fast; and if they go too fast for the board, who are more intimately in touch with the work, aren't they going too fast for the community which has little contact with the work itself?

We find also the tendency to flatter the board member—to make him feel that he is most important in the work. And again, we have the professional worker feeling that the board member should have the agency as his prime interest, forgetting he has other interests and other jobs.

BOARD MEMBERS' ATTITUDES

On the other hand, the board member also has definite attitudes colored by the past. There are some who feel superior to the professional worker, because they are the ones who raise the money and make the agency possible.

We still see occasionally the attitude that the agency, as well as the staff, is their special property.

Again, we find board members "scared to death" of the professional worker.

Sometimes they expect the impossible from the professional workers, feeling that they are almost superhuman and that the work should fill their entire lives.

Occasionally, we find an attitude of distrust, a watching and checking up on the staff. We sometimes find—sad to relate—a gossipy attitude among themselves outside of board meetings, about the professional staff, and occasionally about the confidential material presented at board meetings.

There is still a feeling among some board members that the devotion to the cause of social work or nursing should be so great that the staff should not require adequate salaries and that the satisfaction of service is part of the compensation.

None of these attitudes is healthy in the building of sound relationships.

It is most important for both the board member and the professional worker to recognize the distinct contribution which each one makes, recognizing how important both are for the development of the service itself.

THE "IDEAL" BOARD MEMBER

What does the professional worker look for in his ideal composite board member?

At one time several professional workers collected a list of some of the qualifications which they would like to have in members of their board. Some of

them are given below as follows:

Intelligence
Interest in the work of the organization
Knowledge of special needs of the community
Willingness to assist in the work whenever called upon
An ability to work together
Regular attendance at meetings
Understanding of the confidential nature of the problems taken up at meetings
Vision—ability to look ahead into the future and see future needs
Willingness to take board membership seriously and not as a pastime
Open-mindedness
Sympathetic understanding of people of all religions, nationalities, and classes

THE "IDEAL" EXECUTIVE

What does the board look for in the ideal executive director? Many authorities have listed qualifications. Mr. Elwood Street in his book *Social Work Administration** has many pages devoted to this subject. The lists are so great that one almost feels the authorities are outlining qualifications for an individual who would be far too good to stay on this earth and associate with mere mortals.

However, I have selected a few from these lists. The professional leader of the staff should possess leadership; he should be the proposer of policies to the board and the one to carry out its programs. He should have:

Intelligence
Professional competence in his field, meeting the qualifications outlined by the national organizations in that particular field
Industriousness
Breadth of vision
Ability to initiate, to go forward—not being satisfied with having the organization stand still
Courage and frankness
Loyalty, not only to the organization but to the board, staff, and community
Tact
Ability to work with people
Open-mindedness
A sense of humor
Interest in outside activities—not being entirely lost in the job itself

FUNCTIONS OF THE BOARD

The functions of the board are the defining of policies; the outlining of the extent of the program; the financing of the organization, seeing that adequate funds are raised either directly or through the community chest; and the employment of an executive director qualified to carry out the policies determined by the board.

The executive director has the responsibility for the employing and dismissing of his own staff, with the approval of the board or a personnel committee. Certainly for the efficient and sound administration of any agency, the executive director of the service needs to have complete direction of the members of his staff who are to carry out the program.

The executive director is responsible for the professional policies and procedures, and the work of the staff as a whole. Group thinking by the board and the executive director, who represents the staff at the board and committee meetings, is essential on all subjects. Therefore, the executive director is an ex-officio member of the board and all committees without a vote, and sits throughout the meetings. (This statement is made since there are a few boards who have the executive director send in his report.) Certainly, there is seldom a question which comes up at board meetings that should not have the executive director's thinking upon it, as well as that of the board members.

The practice of inviting other staff members to board meetings to present reports is helpful so that the board may become familiar with members of the staff, and also to give the staff members contact with the board and experience in making talks to them. Too frequently board members and staff members don't even know each other, and the annual meeting is the only time they ever

*Street, Elwood. Social Work Administration. Harper and Brothers, New York, 1931.

see one another; a party for the board and staff where all the board are on one side of the room and the staff on the other is too often a custom!

It is, however, the responsibility of the board to make the definite decisions on personnel policies under which the staff is working. More and more organizations are appointing a committee on personnel policies, representing the board and the staff. The executive director and the president are, of course, ex-officio members and meet with this committee as they meet with all other committees of the organization. Some organizations have called this a personnel committee.

Where the staff is large, and even in some small organizations, the staff has formed itself into a self-governing body known as a staff council. The purpose of this council is to afford an opportunity for the expression of staff opinion in matters relating to the organization and its services. All regularly appointed members of the staff are eligible, but vote only after a period of at least three months' staff experience. Some of these groups have adopted a constitution, elected officers, and appointed committees; and they pass officially on all questions submitted to them by the board, executive director, and staff. Such questions as personnel policies, educational programs, scholarships for nurses, and problem situations, have been discussed by staff councils. Where the staff councils exist they may elect members to serve on the personnel committee.

The national Young Women's Christian Association, the Family Welfare Association of America, and other organizations have published suggested activities for a personnel committee. The American Association of Social Workers has outlined certain standards for employment practices for social workers. The National Organization for Public Health Nursing has in its *Board Members' Manual** an outline of suggested personnel policies for the board to use in relationship to the professional staff. The personnel committee of an agency should gather together these various outlines, analyzing them in the light of their own organization's needs, and work out a personnel manual which is passed on by the board and which is available for the staff and for the board. Each new staff member, upon appointment, should know exactly under what conditions he is working.

Personnel policies which have been outlined by such organizations as those listed above are the following:**

Job specifications

The scope and duties of each position should be defined as clearly as possible. The size of the job is so closely related to the kind and quality of the work performed and the individual worker's capacities that no one standard in regard to amount of work expected would be valid.

Probationary employment

A probationary period of known duration is usually valuable to both parties. This allows the employee opportunity to learn at first hand exactly what is involved in his position and to demonstrate to the executive director his capacity for performing it.

Personnel records

There should be periodic evaluations of the employee's work which should be

*National Organization for Public Health Nursing. Board Members' Manual. The Macmillan Company, New York. Revised edition will be published in September 1937.

**The personnel policies here outlined are taken almost verbatim from "A Statement of Standard of Employment Practices for Social Workers," *The Compass*, American Association of Social Workers, 130 East Twenty-second Street, New York, N. Y., January 1937. The policies under *Retirement, Hours of work,* and *Vacations,* are, however, changed slightly to conform with usual or recommended practices in public health nursing.

recorded along with agency decisions based upon them. Employees should participate in making the evaluations and should know in general their content. Such evaluations should be the basis for continuing employment, transfers, promotions, or dismissals, and should form the basis for the writing of references.

Retirement

It is valuable to set an age when the work and physical fitness of the employee of the staff should be reviewed, looking toward a definite retirement from active work in the organization. The problem of old-age pensions is one that the private agency is faced with very definitely, as all employees of philanthropic organizations are exempt from the provisions of the Social Security Act. It is important for boards to face this problem of pensions for their own agencies.

Notice of resignation or dismissal

The agency should give the employee at least a month's notice of dismissal and a longer period if possible, during which it should pay his salary, even though it should feel it advisable to dispense with his services before the expiration of the notification period. The employee is entitled at the time he is given notice to a definite reason for his dismissal, stated in writing if he prefers, and an opportunity for a fair hearing.

Promotion

Advancement to a more responsible position should be dependent upon the worker's fitness and preparation for the new position.

Salaries

The agency should have a definite salary range with minimum and maximum rates for each type of position. Workers should know what this range is and the basis on which increases are to be expected. Salaries and salary ranges should be subject to regular review. The rate of pay should take into account the cost of an adequate living in the given community, the cost of the professional education required, and the value to the agency and the community of the kind of service the employee gives.

Hours of work

The agency should expect a definite number of hours of work and should not expect or require overtime. The time should be allocated to meet the needs of the agency and the community without necessitating regular overtime work on the part of the staff. An eight-hour day and five-and-one-half-day week should be the maximum.

The best practice provides shorter working hours in the summer with opportunities for frequent Saturday mornings off. Some public health nursing organizations have been operating on the five-day week.

Holidays

Holidays to be observed depend on the customs of the community, but those recognized by the agency should be specifically known to the employee so that he may plan for his use of them.

Vacations

A definite period of vacation with pay should be part of the remuneration for services performed, and is due the employee whether he leaves the agency or continues in its employ. A month has been the usual period for the professional staff, and three weeks for the clerical staff. If he is employed less than a year, the best common practice provides 2½ working days for every month of service.

Sick leave

Sick leave should be allowed for a definite period per year. Ordinary and exceptional instances of periods of sick leave and payment of salary can be cov-

ered by agency insurance provision against this risk.

Leave of absence

Leave of absence for professional study or experience and sabbatical leave are matters of good practice.

Accident policy

The agency should carry workmen's compensation insurance to cover accident to employees in line of duty.

Staff education

The agency should aim to provide sound professional services, and as a part of this should provide aids to the professional development of its staff. Fundamental to this is adequate professional supervision and staff instruction geared to agency needs and staff equipment.

These and other employment policies should be carefully worked out by the boards of social and health agencies in every community. Certainly, organizations carrying on social and health programs in a community should take the leadership in developing sound personnel policies.

How Would You Answer These?

Here are some problems which have been raised by public health nurses who are giving a maternity nursing service to mothers and babies. We are submitting them as a continuation of the series which has been appearing under this title since January 1937. Some suggestions in answer to these questions will be furnished by Maternity Center Association, 1 East 57 Street, New York, N. Y., and will be published in September.

1. What would you suggest to a pregnant woman to make her more comfortable in the very hot weather?
2. What particular points would you emphasize in your instructions to a mother with her first baby for his hot weather care?
3. What would you suggest to a mother for simplifying the mother and mother-in-law problem after the baby comes?
4. If you were caring for a mother and new baby and the mother had symptoms of tuberculosis, what would you do about it?

. . . . .

A gratifying response has been received to the offer of an obstetric reference library to be given the nurse who most satisfactorily answers the question published in this column in May. The Maternity Center Association has extended the "dead-line" of the contest until November 1, so that still more nurses may take advantage of the opportunity. Those of you who have not yet sent in your answers —get out your May issues and win the obstetric reference library!

A Story From Long Ago

THIS POIGNANT yet typical story of a family who were under the care of a visiting nurse in 1909 is reprinted here from two old *Visiting Nurse Quarterlies*. The setting belongs to the era of rapid immigration to America and reflects the high hopes of thousands of families who fled from intolerable conditions to find new opportunities in a free land. At the same time it might well be a story of today, except for the "gas mantles" which were the husband's means of livelihood and which belonged to the period before electricity.

We present it as one of the series of historical articles and reprints from old magazines through which we are recalling the early days of public health nursing in this Silver Jubilee year of the National Organization for Public Health Nursing.

HE WAS a young Russian Jew and a soldier in the Russian army. But life there offered little; and he deserted, fled to Germany, there married a pretty Roumanian girl, and together they turned their faces to America—that land of Hope and Liberty!

He was poor, very poor, but he peddled gas mantles from house to house, and thus managed to earn enough to keep himself and wife. They had three rooms upstairs, and then, a few months after they arrived, a baby was born. It was then that the visiting nurse found them. The mother got along beautifully, and the baby was a lusty little thing, not crying more than babies usually do. The father took charge of everything—wife, child, house—only helped by the nurse in her daily morning visit. He was a devoted husband, and a very apt pupil. The nurse taught him how to wash the baby, how to care for his wife, how to keep the room clean, and how to ventilate properly, keeping the air pure and fresh. He was willing and cheerful—but when he was doing housework he could not peddle, and money was getting low.

One night when the baby was about a week old the mother woke up very hot. She called her husband. He came, removed many blankets, put out the gas fire in the stove, and both soon fell asleep again. But in the night a change came and it grew very cold. The mother awoke with a sharp pain in her side. When the nurse arrived she found her very ill. The district doctor was called. He pronounced it pleurisy. Her temperature rose to 104, her respiration ranged from 48 to 52. Pneumonia developed and the doctor and nurse looked anxious. Hard days now followed. One, two, three weeks, and still the poor girl lay suffering, and the young husband cared for the house and mother and child.

Every morning the nurse calls. She bathes and rubs the patient, changes the linen, and makes her as comfortable as she can for the day. Then she looks at the baby's eyes and tells the father-nurse how to bathe them. He knows all about "cooked water," and three-hour nursing, and fresh air. They still insist upon wrapping up the baby like a little papoose, but perhaps it is better so; for though the father is tender and willing, he is an awkward nurse and the baby is handled in a way which would make one tremble if it were not so tightly rolled.

The mother is still very ill, but they think she will recover. The Hebrew Relief now pays a neighbor to come in and help during the day, but the husband is still alone at night. "I no much

sleep," says he. "First I give medicine, then I fix baby, then more medicine, then warm milk; no time to sleep," and his swollen eyelids attest the truth of what he says. But he smiles cheerfully as he says it, only when he looks toward the room where his sick wife lies does his face become overcast, and he murmurs, "She so sick."

The Visiting Nurse Quarterly, April 1909.

. . . . .

THE END OF THE STORY

Readers of the April Quarterly will remember the story of the young Russian Jew, who was taking care of his wife, critically ill with pneumonia, and the new baby. They will be interested to know that the poor woman was finally taken to the City Hospital, where she lay for ten weeks very ill most of the time. The little baby also was very thin and ill.

The other day, when the nurse called to see her, she had been home three weeks. The baby is now four months old and is fat and rosy. The husband, who was a soldier in the Russian army, has now taken up painting and is working almost all of the time. They intend to move to better rooms soon. The woman was so glad to see the nurse she could hardly keep back the tears as she thanked her for coming. She did not know the nurse's name or where she could reach her, and she had wanted so much to see her and thank her.

The Visiting Nurse Quarterly, July 1909.

Out of the Mail Bag

We all enjoy hearing from our old friends on our birthday. We are sharing with you greetings from two of your old friends and ours—Yssabella Waters and Ada M. Carr—on the occasion of the N.O.P.H.N.'s Silver Jubilee year.

MISS WATERS, to whom we had written for a "pen-sketch" of her memories of the N.O.P.H.N., writes that much as she would like to do this for us her health will not permit it. Miss Waters speaks of her "warm affection for Miss Crandall and Miss Carr—and all who stood so nobly by in the early days of starting the N.O.P.H.N." and wishes the N.O.P.H.N. "a successful Jubilee Celebration."*

Miss Carr writes that she has been living in Catonsville, Maryland since last June. Miss Waters to the contrary, Miss Carr disclaims all credit for having anything to do with the founding of the N.O.P.H.N. and she is therefore unable to write her impressions of that event. Instead, she contributes some interesting memories of the earliest efforts to get together which preceded the actual founding of the organization.

Here is Miss Carr's letter:

I was not even at the meeting when the momentous step was taken. So, though I heard practically everything, so to speak, knowing most of the originators, I would simply be drawing on my imagination which is no longer in its first youth.

There is however one historical fact which I am fairly sure has never been printed in the magazine, which might be of interest now you are being historical. The first *National* meeting of "district" or "visiting" nurses—the term "public

*Yssabella Waters was first chairman of eligibility and first statistician of the N.O.P.H.N. She is now retired and living in Groton, Mass. Ada M. Carr was editor of *The Public Health Nurse* (later PUBLIC HEALTH NURSING) from 1924-1930 and a member of the N.O.P.H.N. beginning in 1913. Ella Phillips Crandall was the first general director of the N.O.P.H.N.

health" being then uncoined—was held in connection with, but as a separate section of the Annual Meeting of the National Conference of Charities and Corrections at Portland, Maine—I think it was in 1905. I had then left the Visiting Nurse Association in Baltimore, and was at the Newport Hospital. However, I went to the meeting—Lillian D. Wald, Jane Hitchcock, Mrs. Stark of Boston, Mary E. Lent, the Superintendent of the Visiting Nurse Association of Baltimore, and quite a lot of others were there. We had meetings separately and took part also in the general program of the conference. I recall that Jane Addams came to our meetings several times. Somehow I think that earliest effort of "getting together" ought to be known. Of course Miss Wald will remember. As usual she was one of the main instigators and the acknowledged leader of the little "very very" earnest group.

It is rather interesting that I left behind—for the only time!—our own Mary S. Gardner, in the Newport Training School of which I was then in charge—and vaguely recall telling her about the meeting later on.

Very sincerely,

Ada M. Carr

HAZARDS OF UNPASTEURIZED MILK

SCARLET FEVER FROM RAW MILK

A recent epidemic of approximately 500 cases of scarlet fever in Owego, Tioga County, N. Y., has been traced to the use of raw milk from an infected cow, according to a statement issued by the State Department of Health. The source of the outbreak was suspected early in the epidemic, and the sale of raw milk from the dairy concerned was stopped on December 23, 1936. This action was followed by a rapid decline in the number of cases.

The investigations revealed that the suspected animal had been taken into the herd at the dairy farm a few days before the beginning of the outbreak. Immediately prior to that time the cow had been on a farm on which it was learned there had occurred three cases of scarlet fever, one of which was in a boy who had milked the cow. The evidence indicated that the animal had acquired the infection there and was infected when sold to the dairy farm.

As a result of this outbreak of scarlet fever, and the determination of its cause, the town of Owego has passed an ordinance requiring the pasteurization of all milk sold there.

—Public Health Reports. U. S. Public Health Service, January 22, 1937.

UNDULANT FEVER FROM A FAMILY COW

Another case of undulant fever recently reported was found to be living on a farm and using milk from two cows kept on the farm. No milk was being sold and there were four members of the family exposed, one of whom had undulant fever.

According to information available the cows were tested; one of them was found to react to Bang's abortion disease and was slaughtered.

This is merely one of a number of instances where undulant fever has resulted from drinking raw milk from the family cow. The repetitions of such experience emphasize the need for having blood tests on cows owned by farmers to furnish milk supplies merely for their own families.

—Connecticut State Department of Health, Weekly Health Bulletin, January 18, 1937.

The Public Health Nurse in the Control of Syphilis and Gonorrhea

By GLADYS L. CRAIN, R.N.
Epidemiologist, Massachusetts Department of Public Health, Boston, Massachusetts

Part VIII
A Summary of the Rôle of the Nurse

THE CONTROL of communicable diseases is admittedly a major public health activity for the protection of the community. In recent years, such rapid progress has been made in scientific knowledge and the perfecting of preventive measures that many of these common plagues of mankind have been virtually eliminated. At one time, for example, smallpox swept through communities in terrifying epidemics. Today, it is a rare experience to see patients with this disease. One state reports that it has not had a single case in the last five years.

No small measure of the success of communicable disease control work has been attributed to the untiring efforts of public health nurses. Their assistance has been accepted as essential to progress because their work is recognized and appreciated in the community and they are cordially received in many homes. This relationship with families gives them an unprecedented opportunity to disseminate widely the facts regarding disease prevention and cure. Such serious and continuous efforts have, nevertheless, failed to include a consideration of syphilis and gonorrhea. Yet these diseases are also amenable to treatment and control.

The already famous 1936 Washington Conference on Venereal Disease Control Work has at last aroused professional groups to the universal danger of these diseases to the family and community. Public health nurses must now face squarely their responsibility. The question of whether they should or should not take cognizance of syphilis and gonorrhea and assist the government in its fight to eliminate these plagues is today a dead issue.

NURSE ONE OF MANY WORKERS

There is, however, considerable confusion expressed by individual nurses and public health nursing agencies regarding suitable nursing activities in syphilis and gonorrhea control work. Many are discouraged by the wide range of activities implicit in such a program. They forget that it involves other agencies than their own and that whatever service the nurse gives to her community must enrich or add to, but not duplicate, what is already being done. A knowledge of resources and purposeful coöperation with agencies already taking part in the control program are as essential to the success of public health nursing services here as in any other community nursing enterprise.

Chief among the important organizations to consider is the health department. The health officer is the official representative of the community in matters of health. Only with his sanction, and with a thorough understanding of the official program and sanitary code, can a contribution of lasting value to the community be hoped for. Also, detailed arrangements with treatment agencies in matters of referral, steering

of patients, and division of responsibilities is vital.

Fundamentally, the control of gonorrhea and syphilis is like that of other communicable diseases. The spread of infection is not checked until the community is protected from (1) the patient, (2) the person from whom he acquired the disease, (3) those to whom he may have given the disease. All known patients must have continuous adequate treatment, and avoid activities which will endanger others. Public health nurses may function most effectively in this program through finding contacts and unsuspected cases of syphilis and gonorrhea, and keeping known cases under active treatment.

In the 1936 Proceedings of the Conference on Venereal Disease Control Work, is the following:

"Because syphilis and gonorrhea are family and social problems and cannot be segregated from other health and social problems, the worker who is trained to see the family as a unit is an important factor in the control program of these diseases. Health supervision of the entire family—usually a service rendered by such workers—constitutes a means of case finding as well as the discovery and treatment of other diseases in the incipient stages."

"The community public health nurse . . . . is one of the most effective assistants in locating new cases and in securing the examination of contacts."[1]

In her daily round of bedside care and health supervision the nurse may learn the identity of contacts of known cases by tactful interviewing. She may also find the unsuspected case if she is alert to abnormal symptoms in members of a family who are being visited for general nursing care. She may uncover significant facts as she guides the patient's conversation during the taking of a family or health history. And through successful teaching of the value of periodic medical examinations, she may assist in solving the health problems of patients with obscure symptoms, and find a logical reason for persuading family contacts to seek medical attention.

Because of the many requests for further practical suggestions, the following summary, which is based upon actual demonstrations of successful work is offered:

The responsibility for keeping patients faithful to treatment belongs primarily to the physician, whether in clinic or private office. Under ideal conditions, the patient is assisted through conferences with the doctor to adjust to his diagnosis, to accept the verdict of long-time treatment and the importance of faithfulness to treatment; to be intelligent regarding precautions needed for the protection of others; and to see his responsibility for identifying his contacts, and for bringing them to medical attention. Unfortunately, teaching and interpretations are not always adequate, and occasionally, even when they are, patients become discouraged and lapse. Inadequate treatment of early syphilis is conducive to a flare-up of infectious lesions; gonorrhea is always infectious until cured; and either disease, if unchecked, may result in serious incapacitating complications and chronic invalidism. Therefore, the patient must be found and returned to medical care for the sake of community protection as well as for his own good.

CAREFULLY PLANNED FOLLOW-UP

The follow-up of such patients is a suitable activity for public health nurses who are working out of, or in coöperation with, clinics, the health department, or other agencies which may have a measure of responsibility for the syphilis and gonorrhea control program. This so-called follow-up service should not be a perfunctory matter. Each visit should be carefully planned so that last-

ing results may be obtained. Briefly, points to consider in such a home visit are:

A. Teaching content:
   1. A reinterpretation of medical orders
   2. Further instructions regarding the nature of the disease and the necessity for continuing treatment
   3. A discussion of ways in which the patient may be assured of protecting his family and associates
   4. Emphasis placed at all times upon the hopeful aspects of the situation, and the possibility of cure
   5. Teaching modified to fit each home situation, and adapted to the intelligence and expressed interests of the patient

B. The patient's reason for lapse from treatment
   1. Economic reasons, illness, misunderstandings, grievances, transportation difficulties, clinic hours conflicting with business or family duties, reactions to drugs: Such reasons are far more frequently the cause of a lapse than wilful negligence.

C. Arrangements for removing obstacle to treatment and reinstating patient with treatment agency

D. Other health and social conditions needing adjustment

E. Need for referral to outside health or social agencies
   (The question as to the right to reveal the diagnosis of patients with syphilis or gonorrhea to non-medical agencies is a frequent one. The plan pursued in each case should be based upon local public health regulations, the approval of the physician or treatment agency, the consent of the patient, and the best interests of the public health.)

THE CONTACTS

As was stated above, the contacts of a given case are as important as the original patient in communicable disease control work. Therefore, follow-up visits must be made frequently to contacts. When it is possible to do so, the patient should be encouraged to take the responsibility for his contacts. He may, nevertheless, find this impossible for various reasons, in which case the public health nurse arranges a home visit. Points to consider in such planning are:

1. The fact that the alleged contact may not have the disease
2. The fact that the contact may be unaware that he has been exposed
3. Tactful methods of explaining to the contact that he may have been exposed to a communicable disease
4. Arrangements for a medical examination
5. Safeguards for protecting the identity of the original patient
6. Methods for protecting the contact from curious associates

Family contacts are also followed up with the consent of the patient. If direct teaching of the family is prohibited, general physical examinations may be urged for other reasons. It is important to help the original patient to see the value of frankness and honesty where the family is involved, in order that their protection may be facilitated, and satisfactory home relationships may be maintained. In all cases, persuasive, constructive methods should be used. The coercive approach brings poor results. When patients are wilfully uncoöperative and a source of danger to others, they should be referred to the health officer.

Follow-up work is usually thought of as an extension of private or public clinic services. It has been estimated that about one third of the patients in the United States who are being treated for syphilis and gonorrhea are handled by clinics.

HELPING THE PRIVATE PHYSICIAN

The private physician is shouldering two thirds of this vast burden. He needs assistance in handling the public health problems and social problems which are concomitants of either disease. This service could be supplied by public health nurses. A serious obstacle, however, is involved in establishing such a coöperative plan. The traditional personal and confidential relationship of physician to patient makes for reluctance on the part of the physician to accept help from an outside organization. Frequently, doctors say they cannot be assured that an agency's rec-

ords will be kept strictly confidential. Therefore, experiments are in order.

Certain organizations are loaning public health nurses, on a time basis, to the private physician for follow-up work. Such a nurse becomes the physician's nurse the moment she enters his office. She reports to her own agency only the number of cases visited for the doctor and time spent. All visits to a given doctor's patients or families are made in the name of that physician. Identifying records are kept in the physician's office. The nurse's visits are for the purpose of giving tangible service to the patient, for teaching and interpreting, for arranging for further care, for planning family contact examinations, and for learning the identity of other possible contacts. In this type of service, there is nothing to disturb the patient's faith in the physician's sincerity regarding the keeping of confidences and interest in him as a person.

The feeling is frequently expressed by many community nursing agencies that because they are not primarily responsible for the control program there is little opportunity to assist with such work. Yet the public health nurse in such an organization has a contribution of inestimable value to make. This work may be carried on within the limits of the general program of her organization.

ADDITIONS TO EXISTING SERVICES

Following are suggestions for certain important additions to existing services:

A. The control of syphilis in pregnancy and the prevention of congenital syphilis are an extension of the maternity program planned in coöperation with existing medical agencies. Points to consider are:
   1. The urgency of early case-finding in pregnancy
   2. The importance of early medical attention for all pregnant women
   3. Prompt institution of treatment for pregnant women found to have syphilis
   4. Immediate arrangements for a completed diagnosis for patients with a positive serology
   5. Arrangements for continued antisyphilitic treatment for patients after the confinement period
   6. Preparations for the examination of newborn babies born of mothers with syphilis
   7. Plans for family contact examinations when the mother has syphilis
   8. Early recognition of family prob'ems, and plans for adjustment (psychological, social, economic)

B. Assistance with the care of patients with early syphilis is logically a part of the community nurse's communicable disease work:
   1. The content of home visits
      a. Teaching
         (1) The nature of the disease (Diagnosis should be interpreted in terms of the patient's home, family, daily social contacts, and his work)
         (2) The purpose of treatment
            (a) Community health protection
            (b) Cure of patient
         (3) The consequences of failure to continue treatment
            (a) Reduces chances for cure
            (b) Endangers others
         (4) Personal and marital hygiene
         (5) Reason for contact examinations
         (6) Precautions—care of dishes and articles of personal use. (Base teaching on accurate knowledge of the disease and of periods of infectiousness)
      b. Prevention of serious complications by the prompt reporting to physician or clinic of any unfavorable reaction to drugs
      c. Nursing care and demonstrations of treatment
      d. Recognition of other complicating social or health problems, and planning for adjustments

C. General nursing and health supervision programs contain all the procedures required for the care of children with congenital syphilis:
   1. Care of the newborn baby with syphilis requires:
      a. Careful consideration of the infectious nature of congenital syphilis in the newborn
      b. Instructions to the family regarding precautionary methods
      c. Contact examinations
      d. Nursing care
      e. Arrangements for hospital care when possible
   2. Care of the child with late congenital syphilis requires:

a. Teaching of the non-infectiousness of late congenital syphilis
b. Instructions regarding the importance of normal activities and social contacts for these children
c. Encouragement of the mother that treatment for herself and child may be continuous
d. Adequate home care—diet, hygiene, and emotional adjustments (as an adjunct to medical treatment)
e. Plans for routine visits to assist the mother with carrying out details of home care of patient
f. Arrangements for family contact examinations

D. Assistance with the control of gonorrhea in a community nursing program is readily carried on in connection with the maternity and communicable disease services. Important considerations in the maternity program are:
1. Attention to all pregnant women with an abnormal vaginal discharge or other symptoms suggestive of a gonococcus infection
2. Arrangements for early medical examinations
3. Demonstrations of treatments such as douches and sitz baths
4. Interpretation of doctor's orders in terms of home conditions
5. Teaching regarding personal and marital hygiene
6. Careful teaching regarding precautions, and the care of pre-adolescent girl children in the family
7. Supervision of the newborn baby to prevent eye infections
8. Nursing care of ophthalmia neonatorum (if, in spite of vigilance, an eye infection occurs)
9. Contact examinations

E. Nursing care of adult female patients with gonorrhea (See points 1-6 and 9 under D above)

F. Nursing care of gonococcal vulvovaginitis in pre-adolescent girls
1. Demonstrations of treatment in the home
2. Teaching of personal hygiene
3. Precautions to prevent the spread of the disease
4. Contact examinations and attempts to identify source of infection
5. Recognition of, and planning for, social and health situations which need adjustment
6. Attention to emotional adjustments

Nurses in schools and industrial organizations may help with case-finding through the observation of symptoms, knowledge of health and progress records, and assistance with medical histories and physical examinations.

When dealing with cases of syphilis or gonorrhea, the nurse must bear in mind the general attitude of society toward these infections. The careless revealing of a diagnosis may permanently destroy the patient's prestige in his community, and jeopardize his chances for earning a living and for satisfactory personal and social relationships.

"Nursing has a wonderful tradition that has come down to it through the ages, that wherever human suffering exists there it is a nurse's privilege to be. Perhaps that privilege can be no better exercised than in ministering to a class of patients whose physical suffering is augmented by the fact that a stigma is attached to the disease which has attacked them. By this ministry a nurse may gain a personal understanding that will perhaps help her to do her part in bringing these diseases out of their present hiding places into the full light of day, where they may be fought and vanquished as have so many other scourges of mankind."[2]

REFERENCES

[1]Waters, Lena R. "Medical Follow-up of the Venereal Disease Patient." Proceedings of Conference on Venereal Disease Control Work, December 28-30, 1936, Supplement No. 3 to Venereal Disease Information, U. S. Public Health Service, Washington, D. C. Pages 99-103.

[2]Gardner, Mary S. Public Health Nursing. The Macmillan Company, New York, third edition revised, 1936. Page 397.

Ingraham, Louise Brown. "The Persuasive Approach with the Infectious Syphilis Carrier." *Journal of American Medical Association*, December 12, 1936. Pages 1990-1995.

Morris, Evangeline H. "What Are the Things a Nurse Should Know About Social Hygiene?" *Journal of Social Hygiene*, October 1936. Pages 307-309.

Stokes, John H. Dermatology and Syphilology for Nurses. W. B. Saunders Company, Philadelphia, 1935. Pages 297-308.

(Concluded)

FOR AN ANNOUNCEMENT OF REPRINTS OF THIS SERIES SEE PAGE 10

What's Wrong With This Radio Talk?

The radio is being used increasingly as a medium for the interpretation of community social and health services to the public. The value of a radio broadcast for publicity depends upon its attention-getting and attention-holding qualities—an art about which we can learn much from publicity experts.

We are publishing here a radio broadcast which violates several of the principles of effective radio publicity. It is a composite of many which have been received at the N.O.P.H.N. office. Read it critically, imagining yourself one of a radio audience, a non-professional listener who knows nothing about the service. List your comments, then turn to page 494 and check with ours. If you think of any more, send them to PUBLIC HEALTH NURSING for publication in a later issue.

This is the last of a series of three "What's Wrong With This?" articles on methods of publicity and public information. The first, on newspaper publicity, appeared in the August 1936 number; the second, on the annual report, in the November 1936 issue.

ANNOUNCER: This is Station PHN. Today we are to have a talk by Miss Mary Wilson, director of the Blanktown Public Health Nursing Service, who will tell us about the work done by the nurses.

DIRECTOR: Good morning. As our announcer has told you, I will tell you about the work of the Public Health Nursing Service. The program offers full maternity care including antepartum, delivery, postpartum and newborn service; also morbidity care, and child health supervision.

In the latter service, of which our child health conferences are an important phase, we of course render no pediatric services, since such cases are cared for by the hospital clinic. However, a pediatrician is in attendance at each session of the child health conferences.

Another phase of the child health program is immunization. The organization advises that every child be immunized for diphtheria by the time he is a year old. Free immunizations are given at the conferences.

The maternity service begins, as I have said, with the pregnant mother. The nurse visits regularly, does a urinalysis and takes the blood pressure, instructs the mother in the hygiene of pregnancy, warns her of the dangers of such abnormalities as toxemias and placenta prævia, and advises her to call a doctor in case of such symptoms as headache, dizziness and hemorrhage. The nurse assists the doctor at delivery and returns to give daily care to the mother and baby for about a week.

Morbidity service includes both communicable and non-communicable diseases. If the patient is desperately ill as in pneumonia, the nurse visits the home twice a day giving full general care, and also teaching the family how to care for the patient between visits and how to carry out the hygiene of the sickroom.

Nursing service is available to everyone, rich and poor, without regard to race, color, or creed. The charge is $1.15 per visit, but can be adjusted on a sliding scale.

ANNOUNCER: Thank you, Miss Wilson, for your informative talk. The phone number of the Blanktown Association is 0011.

Gleanings

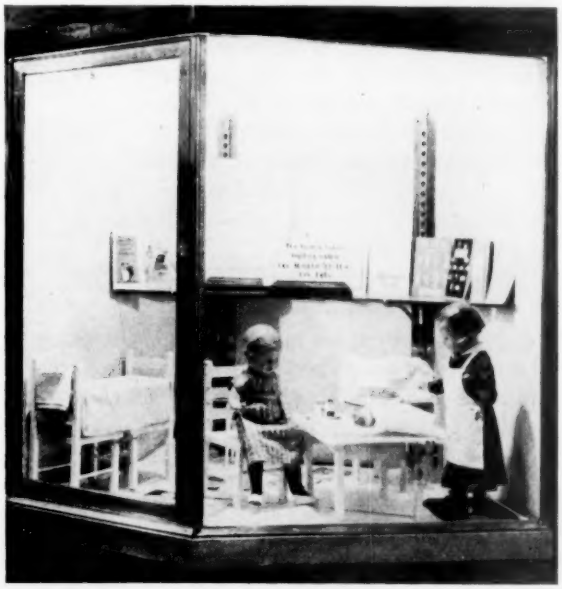
This department is devoted to new ideas regarding improvised equipment, publicity programs, administrative problems, etc. Send us your contributions!

LOOK AND LEARN

Advertising and teaching by means of visual education are considered of great importance today. When our substation was moved recently into an office with a large window facing a busy street intersection, the nurses of the southwestern area of our organization saw the opportunity for some sort of window display. The group decided that a large doll dressed as a visiting nurse would be effective in drawing attention to the posters and literature which were placed in the window. This need was made known to the board member assigned to the district and a large doll was immediately obtained. She was dressed in the visiting nurse costume by one of the nurses and placed in the window, held erect by a rod which passed beneath her clothing to a low standard on the floor.

"Wouldn't it be fun to have her doing something," suggested the nurses, "something which would show passers-by what we actually do." Realizing that babies have an immense appeal, that our organization cares for a quarter of all the babies born in Detroit, and that our own district has a very high birth rate, they decided to have the nurse teaching a mother how to care for her baby.

The next question was where to get the equipment of the proper size, and this problem was solved by a junior high school in the district, whose woodworking class made us a table and chairs. The legs of the table were made to fold neatly underneath to facilitate



"The visiting nurse is teaching the mother how to care for her new baby." So reads the poster in this attractive and arresting display of the work of the Detroit Visiting Nurse Association

moving it from place to place. While the boys were making the furniture, the girls of the domestic art class dressed the mother-doll. A small basket was wrapped in a square of white muslin and placed on two chairs with the legs tied together, thus improvising a bed for the baby. With the addition of a tiny baby doll, a bathtub, a toilet-tray, and a poster of explanation, our display was complete. The dolls stood about 24 inches high and the furniture and other equipment were in proportion, so that the exhibit took up a space of about five feet square. The picture was taken by a high-school student interested in photography; the poster in the picture reads, "The visiting nurse is teaching mother how to care for her new baby."

It was interesting to watch those passing by as they scrutinized the various articles. Men seemed as interested as women, and the children loved it, of course. Literature on the care of babies, habit training, the value of various foods for the family, and many other subjects was also displayed, and many a mother stopped in to ask if she might have a booklet, thus giving us an opportunity to get acquainted with our neighbors and to explain our service.

Then the nurses decided that folks in other parts of the district might like this display as well as those in our immediate neighborhood, and they chose various strategic points in the area, visited the merchants, and explained the plan. They met with instant response and were given much interested assistance. One merchant even changed the display to another window which he decided commanded a better view, and made a larger sign to explain the exhibit. The neighborhood newspaper gave us publicity which amounted to a bit of free advertising for the merchants as well as for our service, and we were invited to come back at any time we might wish to use their windows again.

A toy dresser and bed have been added to our equipment and the display has been altered to show how our nurses care for communicable disease in the home. We have found that this exhibit has not only interested the public and informed it of the fact that our nurses care for communicable diseases in the home, but has been of assistance to our new nurses and students in the substation.

These displays have been shown in many places this past year: in a high school where many of the girls marry soon after graduation; before young students in an elementary school, who were studying community resources; in various types of store windows; and at an American Legion child welfare conference.

CHARLOTTE LIGHT CHILSON,
Supervisor, Visiting Nurse Association, Detroit, Michigan.

FOR THE RURAL NURSE'S MAIL

The simple device of securing a date stamp from the ten-cent store for each field nurse and stamping all incoming mail (including reports of communicable disease) as it is opened has helped bring order in the offices of the rural nurses in one district and has saved them from unjustified criticism about late action on certain cases in a few important instances.

—*Chats*, New York State Department of Health, January 1937

Nurse-of-the-Month

BESSIE J. WOODMANSEE
Washington, D. C.

Mrs. Woodmansee attended elementary and high school in the State of Washington. She finished the nursing course at the Emanuel Hospital, Portland, Oregon, and followed this course by special work in laboratory technique. For several years she worked as a laboratory technician and later attended the University of Oregon for additional courses in science. It was at this time, persuaded by a public health nurse from China, that she decided to change from science to the field of applied sociology.

Mrs. Woodmansee received her Public Health Nursing Certificate and completed the requirements for the B.S. degree at the University of Oregon.

Early in 1935 she was admitted to the staff of the Instructive Visiting Nurse Society of Washington, D. C., and has continued her public health nursing work with this organization, which carries on a generalized public health nursing program.

A CROSS SECTION OF A DAY'S WORK

THE FIRST VISIT this morning will be to Mrs. Brown who was delivered in her home last night. Everything will be ready here as she called the visiting nurses very early in her pregnancy for prenatal advice and help in planning her home delivery. She has always been eager to coöperate in every way and has attended clinic very faithfully.

"How do you feel this morning, Mrs. Brown? Did you say the new baby is a girl."

"Yes, she's a girl. Jim and I are so happy. It doesn't seem possible that we didn't want her when we first knew she was coming. Everything went nicely and I'm feeling fine, but of course I had gone to clinic regularly and the doctors knew my case."

"I wish that every mother could have the same prenatal care that you have had. Having babies wouldn't be a hazardous occupation then."

Mrs. Brown had been glad to know about the clinic as she could not afford a private physician. When her boy was born, her husband had a good job and she had gone to the hospital, but he lost his job very soon afterward and they never did get the bills paid. They finally had to go on relief. Later he was transferred to WPA but the income was small and half of it went to pay the rent on a furnished room where I first visited them. I could understand why they were not very happy about the baby then.

"You certainly have a nice place now, Mrs. Brown, two rooms and a porch, all for less than you paid before."

"This seems grand after living in one room for so long. We were always moving too, because if we weren't fighting

bedbugs, it was cockroaches. I'm glad you urged us to get our own furniture and really have a home. It didn't seem possible at first because we never had any money, but when you told us about the man who made furniture out of packing boxes it gave Jim an idea. We didn't have much to start with, but we kept working at it and I think it looks nice now. We had lots of fun doing it too."

"You both did splendidly. The whole thing is cleverly done. I think it has been a good thing for Mr. Brown too."

"Oh, Jim is a different person. He was terribly depressed after he lost his job. He didn't seem to take an interest in anything until we started working together on our home."

"It's nice to see a husband and wife working together the way you do. I think it has a stabilizing effect on their marriage."

"Did you see the baby's bed? I think it's the best thing Jim has done. It's just the right height and it even has wheels so I can move it easily."

"Isn't that fine? You can wheel the baby out on the porch every day for his nap. I'll move this table closer while I bathe the baby so that you can watch me, and I'll try to explain each step as we go along. Every day we can take up something new in baby's care as I don't want to give you too much to remember this first day."

"I already know that you have to give boiled water and I've given her some twice."

"That's fine, and you can start feeding her on the schedule the doctor gave you. It is best to have a regular time for doing everything and I know you will be especially careful to let nothing interfere with the regularity of her feedings. Keep her warm for the first few days because a baby is accustomed to a warm place and cannot stand any great change in temperature."

"What can I do about all the neighborly advice that I get? The woman upstairs who has five living children and three dead, says that if there is anything that she craved during pregnancy, she always gives it to her babies to keep them from crying. She wants me to give the baby a taste of apple pie because I was so fond of it before she was born."

"Well, I'd be as tactful as possible but very firm right from the first. Let them understand that you are following the doctor's advice and you won't have much trouble with them. Now that I have bathed both you and the baby, I'll leave you in your mother's care until tomorrow. I've given her all the necessary instructions and I'm sure that you will be all right. Good-bye, Mrs. Brown."

I shall visit poor old Mr. Gates next. He gets so uncomfortable if he has to wait until afternoon for the redressing. He lives with his daughter, whose husband has deserted her. As soon as his condition improves enough to permit it, he is to have a second operation.

"Good morning, nurse, father is waiting for you. The doctor says he is strong enough for the operation so he is going back to the hospital tomorrow."

"That's good. By the way, how is your little girl since she had her tonsils out?"

"I went out to the country to see her yesterday and she looks fine. The doctor says her heart is going to be all right. You know I didn't mean to neglect Jean but I never realized that the pain in her legs was anything serious. It was a lucky thing that you suggested that I take her to a doctor. He told me that her heart might have been permanently injured in another year."

"That's why it's so important for children to be examined ever so often. Most of the so-called simple ailments of childhood aren't so simple after all. How long is Jean going to stay in the country?"

"The doctor said to leave her there until the neighbor's children get over the measles."

"That's a good idea. It would be hard on her to have the measles now. Have you talked with the doctor about yourself, Mrs. Smith?"

"Yes, I finally did go to him and I'm to have a metabolism test next week. He says it's some glandular disturbance. I've suspected for some time that something was wrong because my menstrual periods were so irregular. . . . Before I forget it, the little colored girl who lives back in the alley has been watching for you all morning. She says her mother wants to see you."

"Hello, Jeveline! Were you looking for me?"

"Mamma says could you come and see Queen Esther, she's sick."

"Good morning, Mrs. Washington, what seems to be the trouble?"

"Land sakes, Honey, Queen Esther's done cried all night. I put onions and vinegar to her haid to keep the fever down but nothin' seems to do any good."

"We'll see what the thermometer says. When did you first notice that she seemed ill?"

"Well, last week the plaster fell off in the bedroom and it's been right damp in there and Queen Esther caught a cold but she didn't get real bad until last night."

"If you will bring me a basin of water, I'll put her to bed and wash her while you get a glass of fruit juice for her. She needs plenty of fluids."

"She ain't et a thing all morning nurse. I fried her a nice piece of fish but she wouldn't touch it."

"I'm glad she didn't and I wouldn't try to get her to eat any solid food for a while. Now let's move this bed around so that she can have fresh air without being in a draft and perhaps she will sleep for a while. Be sure to wash your hands with soap and water before you leave her room and don't let anyone else use her dishes."

"You don't think it's anything catching, do you?"

"Well, I don't know, we'll see what the doctor says, but even if it's only a cold you wouldn't want Jeveline to get it."

"I almost know it ain't diphtheria. You had to keep after me a long time but I finally took them to the clinic to get the needle. Both of 'em was vaccinated too."

"Oh I'm so glad. I'll try to arrange for you and the girls to go to the camp next summer for a good vacation out-of-doors. I'll call the district doctor right away and I'll come again this afternoon to help you with the treatment the doctor orders. Good-bye, Mrs. Washington."

And so I hurry off to my next patient.

THE AMERICAN JOURNAL OF NURSING FOR AUGUST

At the A.P.H.A. Convention

The following program represents the schedule of activities of public health nurses during the week of October 3, when the National Organization for Public Health Nursing and the American Public Health Association hold their joint meeting in New York City.

MONDAY MORNING, OCTOBER 4

Open House at N.O.P.H.N. Headquarters, 50 West 50 Street.

MONDAY AFTERNOON, OCTOBER 4

General Meeting of the N.O.P.H.N. Membership, Pennsylvania Hotel.

MONDAY, OCTOBER 4, 7:30 P.M.

Dinner Session

Silver Jubilee Dinner, N.O.P.H.N. and A.P.H.A., Pennsylvania Hotel. Principal address—Public Health Nursing Marches On. Thomas Parran, Jr., M.D., Surgeon General, U. S. Public Health Service, Washington, D. C.

TUESDAY MORNING, OCTOBER 5

Public Health Nursing Section. Section Business.

TUESDAY AFTERNOON, OCTOBER 5

Joint Session between Child Hygiene Section and public health nurses.

Pregnancy Wastage. Regine K. Stix, M.D., Research Associate, and Dorothy G. Wiehl, Assistant Director of Research, Milbank Memorial Fund, New York, N. Y.

Stillbirths. Ethel C. Dunham, M.D., Director of Research in Child Development, Edwin F. Daily, M.D., Director, Division of Maternal and Child Health, Clara E. Hayes, M.D., Medical Officer, and Elizabeth C. Tandy, D.Sc., Director, Statistical Division, U. S. Children's Bureau, Washington, D. C.

Maternity Care in Rural Areas by Public Health Nurses. Helen A. Bigelow, R.N., Consultant Nurse in Maternity, Infancy and Child Hygiene, State Department of Health, Albany, N. Y.

WEDNESDAY MORNING, OCTOBER 6

Joint Session between Industrial Hygiene Section, National Society for the Prevention of Blindness, and public health nurses.

Syphilis Control in Industry and Industrial Dermatoses

Syphilis Control in Industry. R. R. Sayers, M.D., Senior Surgeon in Charge, Office of Industrial Hygiene and Sanitation, U. S. Public Health Service, Washington, D. C.

The Rôle of the Public Health Nurse in Syphilis Control. Gladys Crain, R.N., Epidemiologist, Massachusetts Department of Public Health, Boston, Mass.

The Diagnosis of Industrial Skin Diseases. Louis Schwartz, M.D., Senior Surgeon, U. S. Public Health Service, New York, N. Y.

The Rôle of Allergy in Industrial Dermatoses. Marion Sulzberger, M.D., Associate Professor of Clinical Dermatology and Syphilology, Post-Graduate Medical School and Hospital, New York, N. Y.

WEDNESDAY, OCTOBER 6, 12:30 P.M.

Luncheon Session

Report of the National Organization for Public Health Nursing Study of Personnel Practices in Public Health Nursing in Official Agencies. Marian G. Randall, R.N., Milbank Memorial Fund, New York, N. Y.

THURSDAY MORNING, OCTOBER 7

Joint Session between Child Hygiene Section and public health nurses.

The Crippled Child

Development of the Federal Program for the Care of the Crippled Children. Robert C. Hood, M.D., U. S. Children's Bureau, Washington, D. C.

Preventive Aspects of Crippling Diseases. H. E. Hilleboe, M.D., State Department of Welfare, Minneapolis, Minn.

The Public Health Nurse and Orthopedic Nursing Care. Dorothy J. Carter, R.N., General Director, Community Health Association, Boston, Mass.

Social Work and the Handicapped Child. Dorothy Buckner, Supervisor, Social Service Division, ERA, Springfield, Mass.

Education of the Handicapped Child. Bronson Crothers, M.D., Assistant Professor of Pediatrics, Harvard University Medical School, Cambridge, Mass.

FRIDAY MORNING, OCTOBER 8

Joint Session between Child Hygiene and Food and Nutrition Sections and public health nurses.

Nutrition Program in a State Health Department. Woodbridge E. Morris, M.D., Director, Division of Maternity and Child Health, State Board of Health, Dover, Del.

Nutrition in Maternal and Child Health Programs under the Social Security Act. Marjorie M. Hesseltine, U. S. Children's Bureau, Washington, D. C.

Nutritional Education in the Home. The Dutchess County, New York Project. Bertrand E. Roberts, M.D., District State Health Officer, Poughkeepsie, N. Y.

The Nutritionist in the City Public Health Program. Sophia S. Halsted, Nutrition Director, Department of Health, Detroit, Mich.

Education in Nutrition by Private Agencies. James A. Tobey, Dr.P.H., Director of Health Service, The Borden Company, New York, N. Y.

Discussion. Henry C. Sherman, Ph.D., Professor of Chemistry, Columbia University, New York, N. Y.

FRIDAY AFTERNOON, OCTOBER 8

Joint Session—Child Hygiene Section, public health nurses and the American Association of School Physicians.

Practical Procedures in School Health Service. Dorothy B. Nyswander, Ph.D., Director, School Health Study, Committee on Neighborhood Development, New York, N. Y.

Discussion. Amelia Grant, R.N., Director, Bureau of Nursing, Department of Health, New York, N. Y.

The Extent of Seasonal Variation of Intermittency in Growth. Clair E. Turner, Dr.P.H., Professor, and Alfred Nordstrom, Teaching Fellow, Department of Biology and Public Health, Massachusetts Institute of Technology, Cambridge, Mass.

Health Knowledge of School Children with Reference to Health Education. Max Seham, M.D., University of Minnesota, Minneapolis, Minn.

Discussion.

The above is the scientific program only. Sandwiched in between the serious things is an elaborate program of entertainment events and inspection trips in which all public health nurses and the lay members of the National Organization for Public Health Nursing are invited to participate by Dr. John L. Rice, Chairman of the Local Committee for the meetings of the American Public Health Association and allied organizations. There are to be a Fashion Show and Tea, a matinee, and a Garden Trip for women delegates only. There will be two dancing parties following evening sessions for everybody and also a boat trip around Manhattan. There will be opportunities to hear radio broadcasts, to visit Radio City, the Empire State Building, the Normandie, and the Queen Mary, and to do all the general sightseeing for which New York is justly famous.

To wind up the 66th Annual Meeting in a blaze of glory, a post-convention trip to Bermuda is contemplated on the Polish liner Pilsudski, sailing on Friday, October 8 at 8 p.m. and returning on Wednesday, October 13. This trip, with 24 hours in Bermuda, is offered at bargain rates from $50 up. And since the boat will be used in Bermuda as a hotel, there will be no additional expense except the United States and Bermuda taxes, boat tips, and shore excursions—which can all be covered by $20. The American Public Health Association will provide further information.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

WITH THE STAFF IN THE FIELD

With heat waves the order of the day and the staff already depleted by vacation schedules, field activities have diminished considerably. Only three members were out of the office during the past month.

Miss Davis went to Saratoga Springs on June 23, where she attended the Annual Conference of the New York State Health Department, spoke at one of the meetings, and conveyed the N.O.P.H.N.'s greetings at a banquet the same evening, which celebrated the Silver Jubilee of the organization. A very impressive historical pageant climaxed the occasion.

Miss Houlton and Miss McNeil represented the N.O.P.H.N. at the National Education Association convention in Detroit, Michigan on June 27-29.

SILVER JUBILEE HONOR ROLL

August, 1937

ARIZONA
- **Pima County Health Unit, Tucson

ARKANSAS
- **Lawrence County Nursing Service, Walnut Ridge

CALIFORNIA
- ***Metropolitan Life Insurance Nursing Service, San Diego
- **Metropolitan Life Insurance Nursing Service, Southern California

CONNECTICUT
- *Metropolitan Life Insurance Nursing Service, Danielson
- *Visiting Nurse Association of New Britain, New Britain

ILLINOIS
- *City Health Department, Bloomington
- *****Chicago Tuberculosis Institute, Chicago
- **Visiting Nurse Association of St. Clair County, East St. Louis
- **Board of Education, District 89, Maywood

INDIANA
- **City Schools, Crawfordsville
- ***Elkhart County Tuberculosis Association, Goshen
- ***Goshen Chapter, American Red Cross, Goshen
- ***Logansport School Nursing Service, Logansport
- **Metropolitan Life Insurance Nursing Service, Michigan City
- ***Ball State Teachers' College Nursing Service, Muncie

KANSAS
- *****Visiting Nurse Association, Kansas City

MAINE
- ***Lewiston Health Department, Lewiston

MASSACHUSETTS
- *Hanover Visiting Nurse Association, Hanover
- ***Community Health Association of Richmond & West Stockbridge, Richmond

MINNESOTA
- **Jackson County Nursing Service, Jackson

MISSOURI
- **Metropolitan Life Insurance Nursing Service, Moberly
- **Board of Education, Division of Hygiene, St. Louis

NEBRASKA
- **Lincoln and Lancaster County Chapter, American Red Cross, Lincoln

NEW HAMPSHIRE
- *****Lancaster Chapter American Red Cross, Lancaster

NEW JERSEY
- ****Metropolitan Life Insurance Nursing Service, Camden
- **Visiting Nurse Association, Plainfield
- ******Monmouth County Organization for Social Service, Inc., Red Bank

NEW YORK
- ***Erie County Nursing Service, Buffalo
- ***District Nursing Association, Carmel
- ***Visiting Nurse Committee, Millbrook
- ******Public Health Nursing Organization of Eastchester, Inc., Tuckahoe

OHIO
- *Metropolitan Life Insurance Nursing Service, Zanesville

OREGON
- *Deschutes County Health Association, Bend
- *Jackson County Health Department, Medford

RHODE ISLAND
- *****North Providence District Nursing Association, Centerdale

TENNESSEE

*Carter-Unicoi Health District, Elizabethton
***Lincoln County Health Department, Fayetteville
*****Williamson County Health Unit, Franklin
**Summer County Health Department, Gallatin
**Public Health Nursing Service, City Health Department, Memphis

VIRGINIA

***Charlotte County Chapter, American Red Cross, Charlotte

WYOMING

*Lincoln County Health Department, Afton
*Big Horn County Health Department, Basin
*Converse County Health Department, Douglas
*Uinta County Health Department, Evanston
*Sheridan County Health Department, Sheridan
*Hot Springs County Health Department, Thermopolis
*Platte County Health Department, Wheatland

JOINT VOCATIONAL SERVICE

reports the following placements and assisted placements during the month of June 1937:

PLACEMENTS

Clara B. Rue, Assistant Professor of Nursing Education (will direct public health nursing course) Duquesne University, Pittsburgh, Pa.

Helen Gould, Generalized Supervisor, Department of Public Health Nursing, Greenwich, Conn.

Mrs. Clarice Banning Spindle, Director-Supervisor, Public Health Nursing Association, Charlestown, W. Va.

Florence Spaulding, Nurse on teaching staff, Pekin Community High School, Pekin, Ill.

Bertha L. Allwardt, Field Nursing Representative, American Red Cross, Washington, D. C.

Marcetta Horne, Assistant Supervisor of Clinics, Mountainside Hospital, Montclair, N. J.

Mrs. Edna Schreib Moody, Staff Nurse, New York Child's Foster Home Service, New York, N. Y.

Katherine Fallon, Child Health Nurse (part time), Eastside House Nursing School, New York, N. Y.

Jeannette Newhall, Staff Nurse, Visiting Nurse Association, Bridgeport, Conn.

Felicia Whyte, Staff Nurse, Visiting Nurse Association of the Oranges and Maplewood, Orange, N. J.

Mrs. Vesta Bowden, Staff Nurse, Bureau of Public Health Nursing, Montclair, N. J.

Fanny P. Goluboff, Staff Nurse (temporary), Foster Home Bureau, New York, N. Y.

Elsa Scott, Camp Nurse, Camp Woodruff, Milford, Mass.

Ethel Booth, Camp Nurse, Camp Wyoda, Ely, Vt.

Era Dunlap, Camp Nurse, Camp Quinibec, Ely, Vt.

Mary Gauthier, Staff Worker, Social Service Department, Kings County Hospital, Brooklyn, N. Y.

ASSISTED PLACEMENTS

Helen Gallagher, Educational Supervisor, Berkshire Health District, Great Barrington, Mass.

Irene De Sarmo, Public Health Nurse, American Red Cross, Catasaqua, Pa.

Seater-Margaret Drever, Child Hygiene Nurse, Massachusetts State Department of Health, assigned to Pembroke, Mass.

Ruth E. Baker, County Nurse, Westchester County Department of Health, White Plains, N. Y.

Marie M. Ouellette, Staff Nurse, Health Department, Washington, D. C.

Frieda Kornhauser, County Nurse, New York State Department of Health, Albany, N. Y.

Ovidia Evenson, Staff Nurse, Visiting Nurse Association, Detroit, Mich.

DEAD-LINE ON ESSAY CONTEST EXTENDED

Those of you who have been hoping to win an N.O.P.H.N. life membership but who have been just too busy to get started on that essay will be glad to know the dead-line has been postponed until November 1. You remember the prizes (announced on page 224 of the April issue) are to go to the nurse writing the best essay on "What the N.O.P.H.N. means to me as a public health nurse," and to the lay person writing the best essay on "What benefits can my community derive from the N.O.P.H.N.?" The articles are to be not over 1000 words in length. The awards will be announced through the magazine rather than at the A.P.H.A. Convention as previously planned.

Vacation Reading

As our contribution to a pleasant summer we are departing from our usual custom of publishing reviews and book notes on sober subjects related to our profession. Instead, we are offering the following suggestions for light reading:

THE YEARS

By Virginia Woolf. 435 pp. Harcourt, Brace and Company, New York, 1937. $2.50.

The technique of writing a family saga is no mystery to Virginia Woolf, as the history of the Pargiters in *The Years* moves along with ease for three interesting generations.

The Pargiters are ordinary people; their lives typical and unvaried. Their pride and interest in themselves and each other keep the book alive.

In addition to creating vivid characters, Miss Woolf has given us another delightfully clear view of London and the English countryside. M.C.W.

PARADISE

By Esther Forbes. 556 pp. Harcourt, Brace and Company, New York, 1937. $2.50.

Paradise is a historical romance of the early days of the Massachusetts Bay Colony. In the year 1639 Jude Parre and his family with about a dozen others are granted a petition by Governor Winthrop of Massachusetts to settle near Boston on land occupied by the Indians. They call their settlement Canaan. Jude Parre was judge of the village court and administered justice over the villagers and the Indians. He built a huge house which he called *Paradise* after his ancestral home in England. The story centers about himself, his two sons, and his three daughters.

Miss Forbes describes the life of this little village, their conflicts among themselves, and their relations with the Indians. The Parre family felt very kindly toward the Indians and did much to keep an amiable relationship between them and the settlers. After Jude Parre died, the settlers openly showed their contempt for the Indians, and during King Philip's War, the Indians rose up against the settlers, killing many.

Miss Forbes gives a very colorful interpretation of the early colonial history of that particular section of Massachusetts. M.C.L.

EXCUSE IT, PLEASE!

By Cornelia Otis Skinner. 225 pp. Dodd, Mead and Company, New York, 1936. $2.00.

A grand book for vacation reading. Miss Skinner portrays everyday occurrences in a light, interesting, and highly humorous manner. There are nineteen sketches in the book with amusing illustrations by my favorite V. Soglow.

One of the best sketches is the author's version of what a telephone operator does while you wait impatiently, jiggling the receiver up and down, to get your number.

If you travel by plane and really are not nearly as keen about it as you pretend, you will be truly comforted by Miss Skinner's description of her qualms.

The sketches include learning to ride a horse, taking skating lessons, and trying to master the art of ballroom dancing. The author's reactions to electric

shocks and her description of "horsey people" will keep you in a constant roar of laughter. A.N.P.

THE STREET OF THE FISHING CAT

By Jolán Földes. Translated from the Hungarian by Elizabeth Jacobi. Farrar and Rinehart, Inc., New York, 1937. $2.50.

This profoundly human story of a group of exiles in Paris is at once entertaining, colorful, and sociologically significant. It is a story simply and convincingly told. The characters live vividly before us through the dialogue and the brief but effective characterizations. Nothing is overdrawn. The author writes with restraint and sincerity. We identify ourselves readily with the Barabás family and their friends who live on the *Street of the Fishing Cat*, follow them sympathetically — sometimes breathlessly—through their joys and tragedies, their little triumphs and their mistakes. This novel won the international prize in the All-Nations Prize Novel Competition in 1936. The author has written a truly international book of universal human appeal. P.P.

For that rainy day or evening of your vacation:

Prescription—

1 steamer chair, chaise longue or hammock
1 (small) box of chocolates

And

ILL MET BY MOONLIGHT

By Leslie Ford. Farrar and Rinehart, New York, 1937. $2.00.

This well-bred mystery story, if you did not read it in *The Saturday Evening Post*, will take your mind from day sheets and case records and fill it with clues and lovely confusion. Like charlotte russe, a mystery story is good while it lasts, soon forgotten, and not recommended as a steady diet! *Ill Met By Moonlight* is quite good charlotte russe. D.D.

FUN IN BED FOR CHILDREN AND JUNIOR FUN IN BED

Edited by Virginia Kirkus and Frank Scully. 137 pp. and 182 pp. Simon and Schuster, New York, 1935. $1.75 each.

Convalescence is often the most important, and, with a child especially, the most difficult period of an illness. To provide wholesome entertainment that will not center the attention of the family upon him and his ailment is one of the major problems of convalescent care.

These books are planned to meet that need. *Fun in Bed for Children* is intended for boys and girls from six to ten years of age; *Junior Fun in Bed* is for those from ten to thirteen years old. However, even an adult finds that many of the puzzles offer challenge. Several of the puzzles are in the form of a maze and a word of warning is needed lest the young patient strain his eyes or tax his strength by too great persistence in this type of activity.

There are stories and poems either for reading aloud or for the child to read. Many of these are familiar. Not all are in keeping with generally accepted concepts of the best in mental hygiene for children.

Many of the games are "talking games" requiring two or more players; others are writing games, some of which the patient can play by himself. There are many suggestions for interesting the child in some activity which he can pursue once he is launched by a well brother or sister or by an adult. Not the least important of these are suggestions for an indoor garden.

While these books cannot be turned over to the child and expected to solve the problem of entertainment, when carefully used by the thoughtful parent they will assist in diverting a child from the tediousness of staying in bed as strength returns. E.W.M.

• The Chamber of Commerce of the United States in coöperation with the American Public Health Association has announced the Fourth Annual Rural Health Conservation Contest "to promote the further development of rural public health work."

Complete information may be obtained from the Chamber of Commerce of the United States, Washington, D. C., or the American Public Health Association, 50 West 50 Street, New York, N. Y.

• A three-day institute on maternity nursing was held in Bismarck, North Dakota, in May. It was sponsored by the State Department of Health and planned by Dr. Maysil W. Williams, State Health Officer, and Margaret Skaarup, Acting State Supervisor of Public Health Nursing.

The institute, which was open to all public health nurses in the state, had an attendance of about 30. Jane Nicholson, consultant public health nurse of the U. S. Children's Bureau, conducted the institute. Dr. P. W. Friese of Bismarck, and Alfred G. Wardley, Field Representative of the American National Red Cross, addressed the nurses.

• The thirtieth annual meeting of the American Home Economics Association in Kansas City, Missouri, June 21-24, broke previous records for attendance, with a registration of over 2100, equal to about one fifth of the membership. The Missouri and Kansas Home Economics Associations were joint hostesses for the meeting.

A resolution was passed regarding the role of home economics in health education; and another resolution emphasized the importance of the school lunchroom in child health and growth, and urged school administrators to secure professional supervision of the lunchroom by trained persons rather than having it administered on a purely commercial basis.

The term of the present president, Mrs. Kathryn Van Aken Burns, state leader of home economics extension work and assistant professor at the University of Illinois, has another year to run; but her successor, Dr. Helen Judy Bond of Teachers College, Columbia University, was elected.

• A well trained force has been assembled for the new health unit in Jones County, Mississippi, to begin full operation on July 1, with the state and the Commonwealth Fund contributing one half of the total budget. A staff of five persons set up a preliminary service on January 1, and six more will be added when the full program begins. The health officer, Dr. Alton R. Perry, is a Harvard graduate in public health; he will have a staff of five nurses, two sanitation supervisors, a dental hygienist, two clerks, and an "administrative assistant" supplied by the Fund to put records and office routines on a firm basis.

• The Leslie Dana Gold Medal, awarded annually for outstanding achievements in the prevention of blindness and the conservation of vision, was presented this year to Mrs. Winifred Hathaway of New York City, Associate Director of the National Society for the Prevention of Blindness. Mrs. Hath-

away was selected for this honor by the St. Louis Society for the Blind, through which the medal is offered by Mr. Leslie Dana of St. Louis.

• Marion Lucile Harper has been awarded the scholarship in health education offered by the Massachusetts Institute of Technology for 1937-1938. Miss Harper is a graduate of Leland Stanford University and School of Nursing, and since February 1936 she has been on the staff of the Visiting Nurse Association, San Francisco, California.

• The new *Curriculum Guide for Schools of Nursing* is ready at last! July 14 saw it leave the hands of the publisher and ready for distribution at the office of the National League of Nursing Education, 50 West 50 Street, New York, N. Y. The price for a single copy is $3.50; for copies ordered in lots of five or more, $3.

Public health nurses should and will be interested in the Guide because of its emphasis upon the integration of public health and the preventive aspects of disease throughout the basic curriculum and because of its recommendations regarding student affiliation in public health nursing agencies.

• The thirty-second annual meeting of the Missouri State Nurses' Association and the twenty-seventh annual meeting of the Missouri State League of Nursing Education will be held October 25-27, 1937, at the Statler Hotel, St. Louis, Missouri.

• Complaints are received from several states that an individual posing as a shoe salesman, claiming to represent both existent and non-existent shoe companies, is defrauding nurses by collecting deposits on orders for shoes that he never delivers. The individual also gives foot massages and sells a foot-hygiene preparation. Nurses are warned to avoid making deposits on orders to strangers.

NEW APPOINTMENTS

(*For J.V.S. Appointments see page* 490)

Flora Burghdorf, Director of Public Health Nursing, Health Department, Kansas City, Kans.

Ruth Crawford, Executive Secretary-Nurse, Lehigh County Tuberculosis Committee, Allentown, Pa.

Helen Green, Community Nurse, Sudbury Public Health Nursing Association, Sudbury, Mass.

Ruth Hopkins, Community Nurse, Connecticut State Department of Health, assigned to East Hampton, Conn.

Elisabeth Phillips, County Nurse, Westchester County Department of Health, White Plains, N. Y.

Third Prize Entry in N.O.P.H.N. Silhouette Contest. By Catherine Sautter, Newark, New Jersey

(For the winners of the contest, see the June 1937 issue)

CORRECTIONS FOR "WHAT'S WRONG WITH THIS RADIO TALK?"

We are listing here some corrections for the radio talk on page 480.

1. The style is uninteresting. Some suggestions for devices to hold the attention of listeners are:

a. Present a dialogue between a nurse and a citizen, in which the citizen asks questions and the nurse replies.

b. Use a family case story to illustrate various services.

c. Dramatize situations. This may be done by a monologuist or a cast of players, or through episodes incorporated in a talk.

d. Personalize by describing the work of one nurse rendered to typical families. Of course correct names would not be used. (See example under 5.)

2. Unfamiliar terms should be avoided as far as possible. The words listed below should be used only in a broadcast which is primarily educational in purpose, and in which the subject under discussion makes it desirable to familiarize the public with scientific terminology. In this case careful explanation of each term used should be given. Such technical terms as these should, however, be omitted in a publicity broadcast:

antepartum	pediatrician
delivery	urinalysis
postpartum	toxemias
morbidity	placenta prævia
pediatric	morbidity

3. The relationship with physician is very poorly presented. No mention is made of securing medical supervision for the antepartum patient, nor of the fact that service is not rendered to patients except under the care of their physicians. The services of the physician at the child health conference are not explained, nor is any statement made regarding eligibility for this service.

4. The discussion on immunization should include a statement that babies under the care of private physicians are referred to them for advice.

5. The approach should be positive rather than negative. All mention of symptoms should be avoided, emphasis being placed instead on actual service rendered.

EXAMPLE (using story method): Miss Smith, while visiting little Henry Jones who is recovering from measles, learns that his mother is two months pregnant. She urges the mother to see her physician immediately for a medical examination and explains that it is important to visit him regularly throughout her pregnancy in order that he may watch her progress. Miss Smith herself will visit Mrs. Jones regularly and help her to plan for the new baby. When Mrs. Jones with the advice of her doctor decides whether the baby is to be born in the hospital or at home, Miss Smith will help her with arrangements. If the decision is in favor of birth in the home Miss Smith will plan to assist the doctor at that most important event.

She will also make a daily visit to the home after the baby is born. These visits will be more than just for the purpose of giving nursing care to mother and baby. They will be a great comfort and a real education to the family, for some one in the family must learn to care for Mrs. Jones and her baby between the nurse's visits and it is most important to the welfare of both that this be done with the least possible strain on the mother.

6. Explanation of the "care of the sick" (a better term than "morbidity" for broadcasters) is also better presented in story form. A dramatic element may be introduced with the story to emphasize an important point in the service the nurse renders.

7. Charges for the nursing visits should be explained in terms of the cost per visit. The reason for charges should be stated in relation to the sources from which the agency is supported. Fee adjustments also need further explanation in terms of the financial status of the family. It is frequently possible to do this in connection with case stories.

8. Explanation is also needed as to who may call the nurse: doctor, family, friend—in fact, anybody—and the hours when the service is available should also be made clear.